The Face of Global Sex 2010

They won't know unless we tell them

durex network

Our first sex education at school was when I was 14 and it was awful. The teacher who took it obviously didn't want to do it and she just focused on the biology – the difference between boys and girls, that sort of thing. Then we had workshops on contraceptives and preventing infections a year later, but by then I already knew pretty much all they were telling us from the Internet, magazines and talking to friends. My parents have talked to me, although really just about contraceptives, and I can't say they have had any influence particularly. I felt quite knowledgeable by then and realised I should be careful and I have been. I first had sex with my then boyfriend when I was 16 and have had two other partners since then – always with a condom.

Female, 18, Austria

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Foreword

There are many definitions of Sex and Relationships Education (SRE) and many purposes attributed to any SRE programme. However, it seems clear that any effective SRE course should inform about the mechanics of sex; how to control your own destiny by preventing unplanned pregnancy and reduce the risk of transmission of STIs; and how sex can fit in within relationships.

But while there are many approaches to delivering SRE across Europe, the test is whether the programmes delivered have positively impacted on young people's knowledge, attitudes and practices (KAP).

It is also vital that, if effective SRE is to be delivered, then information is gathered on where it is best for that information to be made available, at what age it should be delivered and if the same approach works for both sexes.

Overall, the results for the 2010 *Face of Global Sex* report provide a strong indication of the potential way forward for SRE programmes in the future by highlighting a number of significant issues.

The results show a clear gulf in KAP scores between Eastern and Western Europe, suggesting that it may be beneficial for policy makers across Europe to review their approaches and perform further research to identify why the differences occur.

They also give a clear indication that early delivery of SRE information is critical and that these messages are highly effective if delivered by parents, teachers and healthcare professionals.

However, the report shows that the number of young people referencing parents, teachers and healthcare professionals as their main source of sex education is low in the large majority of countries surveyed. This highlights a clear need for public policy priorities to be changed to increase engagement from parents, teachers and healthcare professionals and provide them with support and confidence to deliver SRE messages.

Another cause for concern is the low level of sexual health KAP among young males in all the countries surveyed compared to young females. This significant gap needs to be addressed urgently if the sexual health of future generations is to be protected.

By raising these issues I hope that this report proves useful in helping to inform educationalists and policy makers in the creation of SRE initiatives in the future.

Peter Roach
Vice President, Durex Network

Overview

YouAct is a European youth network of 25 young people from 15 European countries who are active in the field of Sexual and Reproductive Rights.

As an organisation working for and with young people in Europe, we welcome the Durex Network's 2010 *Face of Global Sex* report and its findings. Research such as this helps to inform and support the work of organisations and young people focusing on sexual and reproductive health and rights. It also provides evidence of the needs of young people, their experiences, attitudes and knowledge, which in turn leads to more well-informed, needs-appropriate and effective programming and project implementation.

The Durex Network's 2010 *Face of Global Sex* report focuses on 15 European countries and examines the sexual health knowledge, attitudes and practices (KAP) of young people in these countries. It explores differences in levels of KAP and whether they can be explained by age, gender, age at first sex education, country or region of residence, source of sex education or relationship status.

The research findings show that, overall, you would expect someone with a higher KAP score to be from Western Europe, female, to have received sex education from an early age, be single or dating and have had a small number of sexual partners. The research findings on the positive impact of early sex education on young people's knowledge, attitudes and practices, is extremely important and contradicts those who oppose comprehensive sexuality education and argue that early sex education increases sexual risk. The findings of this report show the opposite to be true, and that there is an urgent need to ensure access to comprehensive sexuality education and information across Europe to improve levels of young people's sexual and reproductive health and wellbeing.

The research also shows the need to focus on education strategies and programmes that include the specific needs of young males across Europe. It shows that you would expect someone with the most limitations against their KAP score to be from Eastern Europe, male, married, have a high number of sexual partners and have limited access to sex and relationship education and information. Unless the experiences and needs of young men across Europe are taken into consideration in the design and development of sexual health programming, these differences in KAP levels between young females and young males will continue, with negative sexual and reproductive health consequences for all young people.

As an organisation that has members representing a number of European countries, we recognise the varying levels of KAP score between young people across Europe, but are concerned in particular by the significant differences between Eastern and Western Europe. The report highlights the lack of awareness of risk, low levels of condom usage, lack of knowledge regarding reproductive health and low levels of confidence and condom negotiation skills particularly in countries within Eastern Europe. With members and partners working within these countries, the significantly low KAP score of young people in Turkey and Hungary is of great concern to us, both as an organisation and as young people of Europe. This report provides evidence for the real need for improved programming in these and other countries with low KAP scores.

As with previous Durex *Face of Global Sex* reports, YouAct is pleased to see the focus on the importance of understanding young people's varied and complex experiences and needs and how recognising this diversity is key to developing effective programming for young people's sexual and reproductive health. Having been invited to provide an overview for this publication, as well as provide case studies and input into the research, YouAct commends the Durex Network's support for youth participation and for really recognising and seeking to improve the situation of young people across Europe.

Mari-Claire Price and Fatma Hacioglu

YouAct
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Introduction

The Durex Network is a firm supporter of academic research into factors that can affect sexual health and which can ultimately lead to strategies that can be used to have a positive effect on the population.

The Durex Network was formed in 2005 out of Durex's successful social marketing activity. As the world's largest condom maker, Durex has always worked closely with politicians, healthcare professionals, non-governmental organisations, educators and charitable bodies worldwide to promote good sexual health.

Its vision is to inspire people to take responsibility for their sexual health, based on the principle that information leads to knowledge which, in turn, leads to action.

The Durex Network has been producing its *Face of Global Sex* reports since 2005. The reports have been ground-breaking in determining factors that affect the sexual health and behaviours of people all over the world.

In the 2009 *Face of Global Sex* report the focus was on young people in seven Eastern European countries to determine whether they felt the need for more sex and relationships education and what factors influenced this perception.

In this, the fifth of its *Face of Global Sex* reports, the Durex Network explores the broader issue of sexual health knowledge, attitudes, and practices (KAP) among young people in 15 European countries – nine in Western Europe and six in Eastern Europe.

Research was carried out during 2010 among statistically relevant numbers of 15-20 year-olds in each of the 15 countries. It looked at their experience of sex education and the report analyses the data to identify potential determinants of higher levels of knowledge, attitudes and practices of sexual health.

The main research question addressed by this study is: What is the level of positive reproductive health knowledge, attitudes and practices among European young people aged 15 to 20 years?

Based on this initial assessment, specific questions have been addressed, including:

1. Do reproductive health KAP scores differ across European countries?
2. Do reproductive health KAP scores differ between Eastern and Western European countries?
3. Do reproductive health KAP scores differ by gender and age?
4. Is the variance of reproductive health KAP scores explained by the age at first sex education, the source of sex education, and/or relationship/ residential status?

The results are presented using countries as the main unit of analysis and are used to address these four questions concerning reproductive health KAP scores.

> You couldn't fault our sex education at school and I do feel knowledgeable and confident as a result. It started at primary school with the basics about puberty. Then when I was 12 and in secondary school we had a whole day of sessions from an outside agency about sex and relationships – including a talk from a mother who had had a child when she was 15. She told us about the problems and stigma she'd faced and that had a real effect on us. My dad did sit me down for a talk once but I'd heard it all by then and I told him that, so he was happy to leave it to the school. And if I need to find anything out now I can always use the Internet or ask my friends.
>
> **Female, 19, UK**

Methodology

A research protocol was developed and approved by the ethics committee of Ghent University. The protocol can be viewed at www.durexnetwork.org.

1. Data collection

Data was collected online by a research agency, Trendwolves, which was commissioned by the Durex Network to undertake this task in 15 countries – Austria, Belgium, France, Germany, Hungary, Italy, Lithuania, Netherlands, Poland, Romania, Slovenia, Spain, Switzerland, Turkey and the United Kingdom. Additional data was provided by Panel Wizard for The Netherlands.

The activity was carried out following the procedures set out in the protocol and 15,768 young people between the ages of 15 and 20 responded in total. The numbers by country are shown in the tables in Appendix 1.

2. Methods of analysis

Most of the methods of statistical analyses proposed in the research protocol were followed for calculating the results of the study. However, some specific methods will only be used for future country-specific studies.

The specific statistical analyses conducted for this initial study were:

- All variables included in the final dataset were reviewed and checked for inconsistencies and missing numbers
- Codebook of all variables for identification of quartiles, means and medians of all variables
- Calculation of mean and 95% confidence intervals for all variables, especially the ones included in the final KAP survey
- Calculation of standardized Cronbach´s alpha of final scoring KAP scale, including specific calculations for each one of the three domains (knowledge, attitudes, and practices)
- Principal components analysis of final scoring KAP scale variables
- Test of normal distribution (Swilk test) of final scoring KAP scale
- Generation of summation graphs for final scoring KAP scale
- Development of a multiple linear regression model for identification of specific associations between various independent variables and final scoring KAP scale (geographical clustering adjustments made)
- Generation of specific two-way associative graphs for specific independent variables over dependent variable (scoring KAP scale)
- Based on a significant prediction identification of the multiple linear regression model, identification of specific coefficients of association, levels of predictability, and modelling assumptions final testing.

3. KAP scale validity and reliability tests

Using the three domains of a KAP scale and only non-virgin respondents, specific variables included in the final questionnaire were grouped together for the development of a factor analysis and levels of loading for all specific variables. Dummy variables were generated varying from -1 to 1 based on the responses included in the different categories of each variable.

For binomial variables, 1 was attributed to an expected response (positive sexual health), -1 to an unexpected response (negative sexual health), and 0 to “don’t know” answer.

For categorical responses using a five level Likert scale, 1 was attributed to an expected response (most positive sexual health), 0.5 to an expected response (positive sexual health), 0 to neutral, -0.5 to an unexpected response (negative sexual health), and -1 to an unexpected response (most negative sexual health).

Then, an exploratory factorial analysis was performed on each of the three domains to confirm variables and factors that contribute to explain overall variation of the final scale. This was an important step to make sure that the final KAP scale would reach pre-defined target levels of reliability and validity before the use of regression models for final hypotheses testing and statistical inferences.

Based on factorial analysis of the three domains and the identification of specific dummy variables with reduced levels of loading, a validity check was made based on the international literature and with a group of experts for a final decision on whether the identified variable or variables should be dropped out of the scale. Also, it was expected, that the Eigenvalue in-factor analysis would be higher than 1.0 with a minimum level of cumulative explanation for the variance over 40%.

After dropping one variable from the final KAP scale, a final reliability test was performed using the Cronbach´s alpha formula. According to the international literature, an alpha of 0.70 should be considered an adequate consistency result. As illustrated in Table 1 below, for all countries, the reliability alpha reached 0.70, and for calculations including the full dataset, the reliability alpha was over 0.75.

Table 1: Reliablility Alpha (dropping p06)

Country	Alpha KAP
Austria	0.7509
Belgium	0.7295
France	0.7348
Germany	0.7448
Hungary	0.7055
Italy	0.7302
Lithuania	0.7335
Netherlands	0.7183
Poland	0.6941
Romania	0.7724
Slovenia	0.7470
Spain	0.7224
Switzerland	0.6932
Turkey	0.6901
United Kingdom	0.7843
ALL	0.7547

Therefore, a final KAP Scale was generated using the structure presented in Table 2:

Table 2: KAP Scale Structure

Domain	Variables	Point Range	
Knowledge	17 variables	-17	+17
Attitudes	17 variables	-17	+17
Practices	7 variables (p06 dropped)	-7	+7
KAP	41 variables (p06 dropped)	-41	+41

As demonstrated in Table 2, the final KAP scale range was set at -41 to +41 points (a range of 82 points), with 17 variables included in the ‘knowledge’ domain, 17 in ‘attitudes’, and seven in ‘practices’.

Introduction to main findings

The findings provide an overview of the variation in levels of KAP among young people in the 15 countries surveyed and indicate that differences in KAP scores exist between Eastern and Western Europe, with the West scoring significantly higher.

They also showed a number of other important key findings:

- Young females in each of the 15 countries had higher KAP scores than their male counterparts
- Early sex education showed a positive impact on KAP scores. A central argument of some who oppose comprehensive sex education is that giving individuals information about sex may increase sexual risk (Dodge et al 2005). The outcomes of our study clearly suggest the opposite – sex education seems to decrease, rather than increase, sexual risk
- Having fewer sexual partners is an indicator of having a higher KAP score
- Relationship status for young people is another significant indicator – those who were married had a lower KAP score than those who were dating
- Current source of sex education had a significant impact – with those receiving information from health professionals, parents and teachers having the highest KAP scores. This supports the findings of Holtzman and Robinson (1995) showing high school students who discussed HIV with their parents were less likely to have unprotected sex than those who only talked to their peers.

The results clearly indicate a need for a focus on educational strategies for male youths and that this could be benefited by providing more support for health professionals, teachers and parents in providing sex education. The need of support for teachers was highlighted in a UK study carried out in 2010 by Durex in partnership with National Confederation of Parent Teacher Associations (NCPTA), the National Association of Head Teachers (NAHT) and the National Governors Association (NGA).

The results also enable the profile of a person with a high KAP score to be created. As a result you would expect a person with a high KAP score:

- To be from Western Europe (probably Austria or Switzerland)
- To be female
- To have had a small number of sexual partners
- To have had sex education from an early age
- To have received sex education information from health professionals, teachers or parents
- To be single or dating.

It is important to note, however, that while the results of the study provide useful Europe-wide intelligence, this report does not include in-depth results for specific countries. Further analyses will be conducted in the future to develop manuscripts which will be submitted to international scientific journals for peer review.

Table 3: Multiple Linear Regression Results for Sexual Health KAP Scale

KAP scale	Coefficient	P>t	95% Confidence Interval	
Belgium	-3.10	-	-3.87	-2.33
France	-1.91	-	-2.92	-0.90
Germany	-1.76	-	-2.63	-0.89
Hungary	-6.78	-	-7.81	-5.75
Italy	-3.68	-	-4.68	-2.67
Lithuania	-4.81	-	-5.95	-3.68
Netherlands	-3.82	-	-4.88	-2.75
Poland	-3.15	-	-4.20	-2.10
Romania	-2.61	-	-3.57	-1.65
Slovenia	-2.18	-	-3.23	-1.12
Spain	-1.89	-	-2.83	-0.94
Switzerland	-0.08	0.86	-0.95	0.79
Turkey	-11.55	-	-12.73	-10.36
United Kingdom	-1.78	-	-2.74	-0.82
Actual age	0.04	0.56	-0.08	0.15
Male	-2.52	-	-2.88	-2.15
Married	-2.68	-	-4.09	-1.26
Single	-0.69	-	-1.05	-0.34
Living with parents	-0.78	0.01	-1.38	-0.19
Living with partner	-2.08	-	-3.09	-1.08
No. sexual partners	-0.11	-	-0.16	-0.05
Siblings	-0.06	0.93	-1.30	1.18
Health professionals	2.62	-	1.83	3.42
Magazines	0.89	0.01	0.19	1.59
Parents	1.86	-	1.33	2.38
Teachers	1.31	-	0.77	1.84
The Internet	1.11	-	0.61	1.61
Age at first sex education	-0.18	-	-0.25	-0.10
Reference group	24.53	-	22.08	26.98

Country and regional differences

The descriptive results of the research are presented in the tables in Appendix 1. The tables also include the total sampling (including virgins) for each country. The large majority of respondents (more than 60%) in 13 of the 15 countries surveyed were non-virgins, with the exceptions being Poland and Lithuania.

The age at which they first had sex education varied widely from 11.5 years in Austria and Slovenia to 14.9 in Turkey and as high as 15.3 in Italy.

Levels of sexual health knowledge were consistent throughout all 15 countries, other than variances in beliefs about STI transmission. For example, in Hungary, Romania and Turkey 40% believed that STIs could be transmitted via toilet seats, whereas the figure for Belgium and France was considerably lower at below 20%.

There was also a disturbingly high number of respondents in Turkey (27%), Italy (21%) and Germany (17%) who believed that women could not become pregnant the first time they have sex.

Young people in the majority of the countries think that they are at no risk of transmission of STIs. This is especially true in Poland and Spain, where the proportion of young people believing themselves to be at little to no risk of STI transmission reached 86% and 84% respectively. In contrast, 50% of Germans felt that they were at moderate to great risk. When it came to condom use with a new partner, young Belgians were second only to Turks (61%) as being the least likely to use one – only 82% of them agreed that they would.

In all 15 countries, only a very small percentage of young people disagreed that using a condom with a new partner was a smart idea. The proportion was below 2.7% everywhere except Turkey, where the figure reached 5.9%. Aras et al (2007) in their study of risk-taking behaviours of students in Turkey confirm that use of condoms at first sex was low.

However, when the respondent already knew their new partner, the proportion of young people fully agreeing that using condoms was not necessary reached more than 22% in Germany and Austria, and more than 43% in Turkey. This data reinforces the findings by Gokengin et al (2003) stating that young people in Turkey are sexually active but not equipped with sufficient knowledge to adopt responsible behaviour.

Furthermore, some 58% of Turks say that condoms diminish their enjoyment of sex – almost 20% higher than the next country – and almost half (49%) still feel embarrassment in purchasing or obtaining condoms, which could be linked to religious beliefs.

Attitudinal questions also resulted in significant differences across countries for statements such as:

a) “It is easy to discuss condoms with prospective partners”

b) “Sex education leads you to begin sex early”

c) “Teachers do not have sufficient training to teach sex education”.

German young people are the most likely to feel that discussing condoms with new partners is easy – with more than 73% of the respondents agreeing. They are closely followed by the Swiss (72%) and Romanians (69%). Those that find such discussions the hardest are the Poles (47%).

When it comes to the question of whether sex education leads to young people starting their sex lives earlier, the highest percentage to disagree of all the nationalities surveyed are the Dutch (58%). The lowest percentage is found among the Turks (25%).

Turkish and Polish youth are most likely to believe that teachers do not receive proper training in sex education, with more than two thirds of all respondents supporting the statement. This contrasts with France where the rates are nearer a third.

The results also showed that the majority of non-virgins used condoms the last time they had sex. In all 15 countries, except the Netherlands (49%), more than half of respondents reported having used them, with Spain reaching more than 78%.

A large majority said that when they had used condoms they did so for both birth control and to prevent infection. The highest proportion of people who had never used a condom was in the UK (20%) and the lowest in Romania (6%).

In order to conjugate all these variables, a KAP scale was used for better evaluation of overall KAP trends and differences among all participating countries. Once validated and tested for reliability, the scale was also used for analysing the potential impact of different population profiling, sources of sex education and geography over sexual health knowledge, attitudes and practices.

Based on summation calculations for all non-virgins and valid responses for all variables included in the final scale, Table 4 shows the mean values and 95% confidence intervals for each of the 15 countries included in the final study.

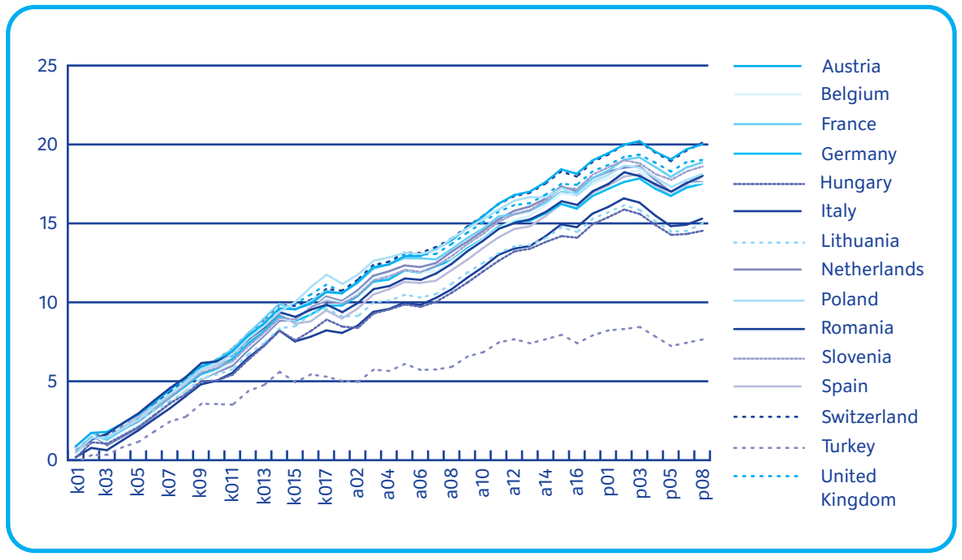
Table 4: KAP Scale Country Averages

Country	Mean	95% Confidence Interval
Austria	20.71	20.05 – 21.37
Belgium	18.16	17.40 – 18.92
France	19.38	18.40 – 20.37
Germany	18.63	17.73 – 19.52
Hungary	15.22	14.20 – 16.23
Italy	16.01	15.10 – 16.92
Lithuania	16.44	15.29 – 17.58
Netherlands	18.18	17.14 – 19.23
Poland	18.97	17.94 – 20.00
Romania	18.62	17.68 – 19.56
Slovenia	19.56	18.49 – 20.64
Spain	19.02	18.12 – 19.91
Switzerland	20.56	19.69 – 21.44
Turkey	8.16	7.08 – 9.23
United Kingdom	19.85	18.89 – 20.81

Austria was the country that reached the highest KAP score (20.7), based on a simple descriptive analysis of all the variables in the scale. This was followed by Switzerland (20.6). The countries with the lowest KAP levels were Turkey (8.2) and Hungary (15.2).

Specific summation trends can be demonstrated in Graph 1 for all 15 countries. In the horizontal axis, all 41 variables are lined up in the same order as they appear in the questionnaire. In the vertical axis, the total of each variable with a total of the value up to its immediate antecedent variable was calculated.

Graph 1: KAP Scale Summation for All 15 Countries



For all 15 countries, a specific trend was found for transitions from the 'knowledge' domain to 'attitudes' and from 'attitudes' to 'practices'.

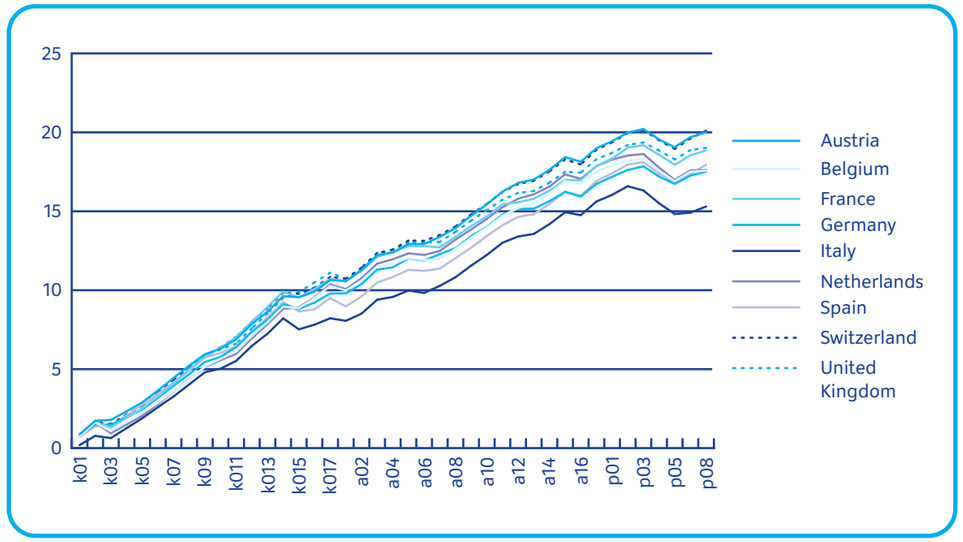
For 'knowledge', scale values experience a linear increase, but the shape of the curve changes once it reaches 'attitudes', and becomes flat to a negative trend once it reaches 'practices'.

Some specific groups of countries can also be identified based on this graph. Turkey stands alone at the lowest bracket. Hungary/Italy/Lithuania have lower totals compared to Belgium/Germany/Netherlands/Poland/Romania, and also if compared to France/Slovenia/Spain/United Kingdom. The two countries reaching the highest KAP levels throughout were Austria and Switzerland.

Some of these trends and differences also become clearer by subdividing the results for all 15 groups based on their regional location in Europe: Western vs. Eastern as shown in Graphs 2 and 3.

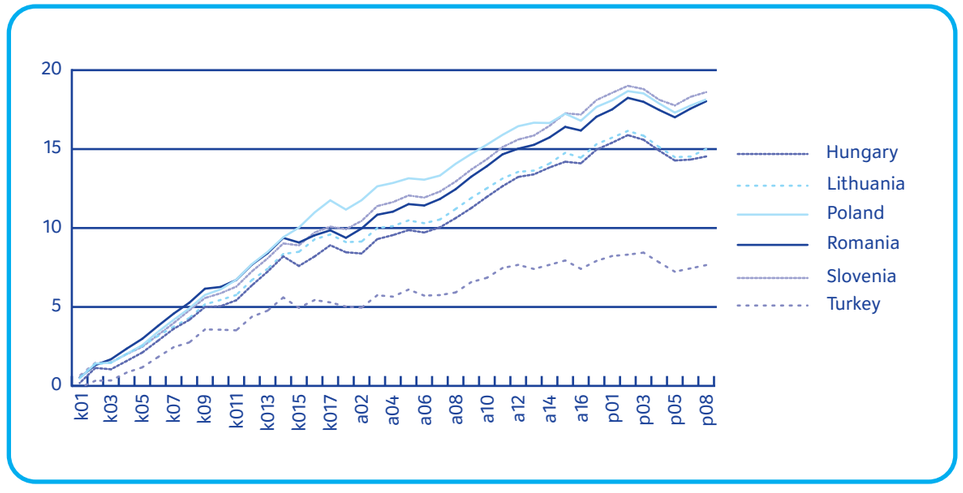
The results show significant statistical differences across Europe. Overall, young people living in Western European countries reached a far higher KAP scale for sexual health than those in Eastern Europe.

Graph 2: KAP Scale Summation for Western European Countries



For Western European countries (Graph 2), Italy stands alone with the lower total KAP levels, and the differences for Austria/Switzerland, France/Spain/United Kingdom, and Belgium/Germany/Netherlands become more evident.

Graph 3: KAP Scale Summation for Eastern European Countries



Three very distinct groups of countries can be identified in Eastern Europe. Poland, Romania, and Slovenia reached the highest average KAP summations, followed by Hungary and Lithuania. The results for Turkey once again showed a significant separation from all other countries in the region.

Social demographics and differences in KAP

The main independent variables for analysis of social demographic differences used for the final model were: a) actual age; b) gender; c) relationship status; d) residential status; e) number of sexual partners; f) current sources of sex education; and g) age at first sex education.

The reference group chosen for this model was: respondents from Austria, female, dating, living alone, and with friends as their current and main source of sex education.

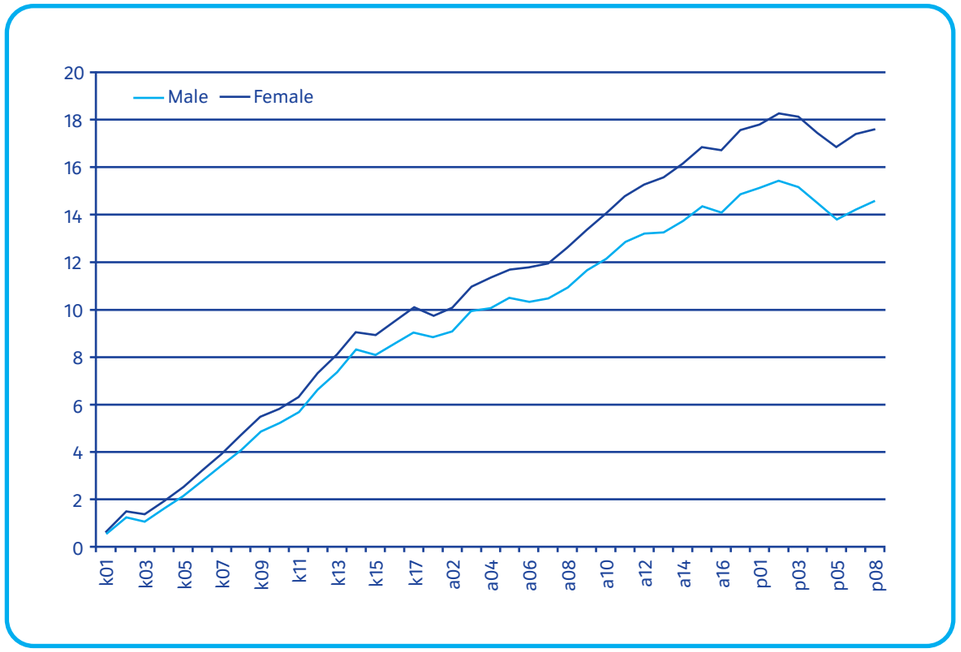
Age and gender

On average, young women from all 15 countries demonstrated better results in the final KAP scale than young men.

Although this difference was found in gender – it was not the case for age. A one year increase in the age of the respondent did not reflect a significant change in the mean value of the KAP scale for sexual health.

The gap between young males and young females is also confirmed using a summation graph for all 41 KAP scale variables as presented in Graph 4. The detachment of the two curves becomes even more evident starting with the 'attitudes' domain and reaching the widest gaps after the 'practices' domain variables are summed up.

Graph 4: Durex KAP Scale



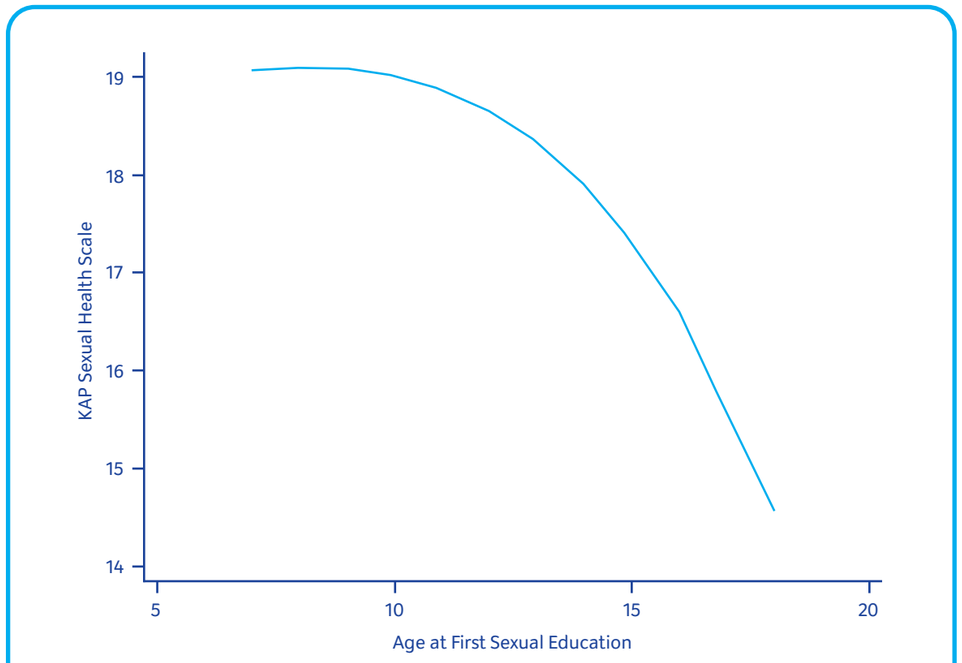
These findings corroborate the international literature on key differences between young males and females in their interpretation of sexual health and sexuality. As reported by Barker in 2000, "The sexual script of many adolescent males would suggest that they are well-informed about issues of sexuality and reproduction, but survey research contradicts this".

Studies conducted in various parts of the world provide significant evidence that young males are ill informed about sexuality. For example, according to Barker, "various surveys in Latin America have found that many men, adult and young, think they possess adequate information about sexuality and reproduction, when in reality they have little information". And, in Denmark, about half of the adolescent males aged 16-20 never talk to their parents about sexuality.

Also, other literature evidence shows a changing trend in the focus for sexual health education. According to Park and Breland (2007), "although the field of sexual and reproductive health has traditionally focused on women, the past decade has witnessed increased national (in the USA) attention to men's sexual health needs". This is an important analysis, considering that the results show that a need exists for engaging young males in more comprehensive approaches to human sexuality. This, in turn, will have an important impact on their future relationships and their parental skills and abilities to prevent a vicious cycle of non-healthy normative behaviour, such as machismo-ism and other forms of negative male roles in society.

It is also important to highlight that these results are just a quantitative measure of levels of sexual health KAP. There are several qualitative aspects that should be taken into consideration for the development and identification of successful sexual education interventions. Sexual health is not just a matter of responding positively to a set of sexual health questions and socio-demographic characteristics, but should also be analysed with consideration to the emotional and individual aspects that are key to explaining actual behaviour, especially among young males.

Graph 5: KAP Sexual Health Scale vs. Age at First Sexual Education



Age at sex and relationships education, number of partners, and relationship status

The age at which young people first received sex education was demonstrated as resulting in a significant difference in average KAP values – as shown in Graph 5. For every year of delay in starting sex education, average KAP values drop by 0.18 points. Therefore, young people who are exposed to sex education at an earlier age present higher levels of KAP for sexual health.

This finding is one of the most significant results of the study. Considering that some sexual experts believe that early sex education may lead to adverse sexual health consequences, such as early sexual experience and an increase in the number of partners, these results suggest that the positive role of early sexual education overcomes negative (if any) effects. In fact, comprehensive reviews of the literature, such as the ones conducted by Kirby (2002), suggest that the association between early sex education and sex initiation/number of partners is negative.

Therefore, results showing that early sex education has a direct effect in increasing the levels of sexual health KAP assist in the understanding of the key role of premature exposure to comprehensive sex education among young boys and girls. It is interesting also to note that this finding confirms similar associations from previous *Face of Global Sex* reports (2008 and 2009).

Previous findings suggest a "window of opportunity" for sex and relationships education between the ages of 11 and 16 to increase sexual confidence in later life and a strong association between exposure to early sex education and less need for more sex and relationships education.

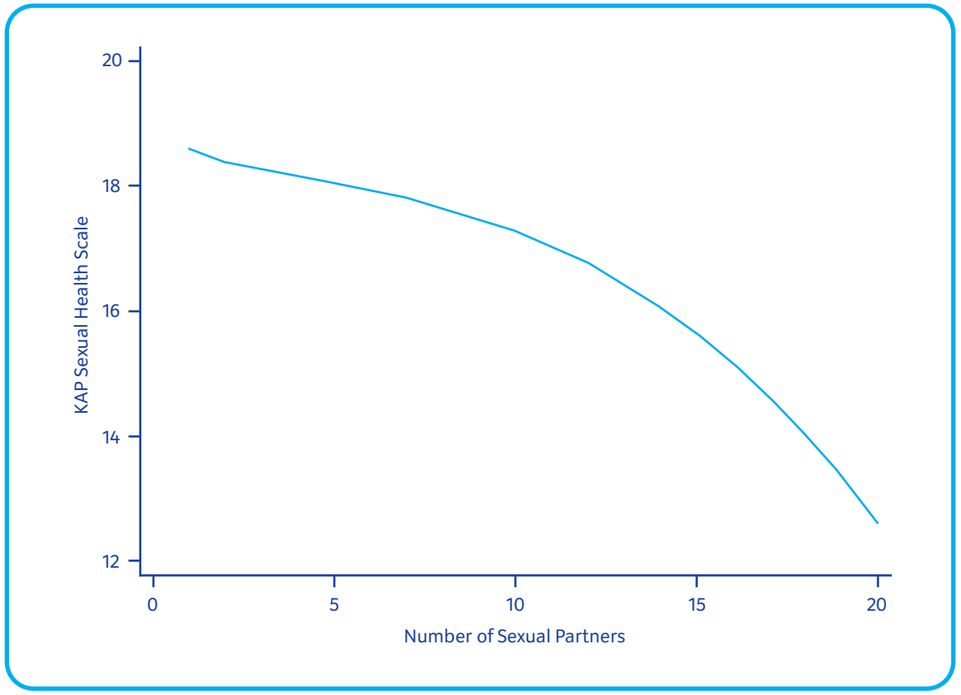
Earlier *Face of Global Sex* reports have also suggested the strong association between an increasing number of sexual partners and adverse sexual health outcomes. In the 2005 edition, a significant statistical association was found between increasing number of sexual partners and unprotected sex. And, this year's study shows that having higher levels of KAP in sexual health is evident among young people who have had sexual experiences with fewer partners. In this case, one additional sexual partner reduces, on average, the KAP level by 0.11 points.

However, there will always be contradictions, as the results of the research show. Young people in Austria, for example, have the highest KAP level and were on average the youngest to receive sex education at 11.5 years, yet have had an average of 4.4 sexual partners. This is more than any other nationality except Turkey and Germany.

At the other end of the scale, Italians are the oldest to receive sex education (15.3 years) but have had a very similar number of sexual partners (3.9) to the Swiss (4.0), for whom sex education starts at an average of just 11.9 years.

The main association between the sexual health scale and the number of sexual partners is presented in Graph 6.

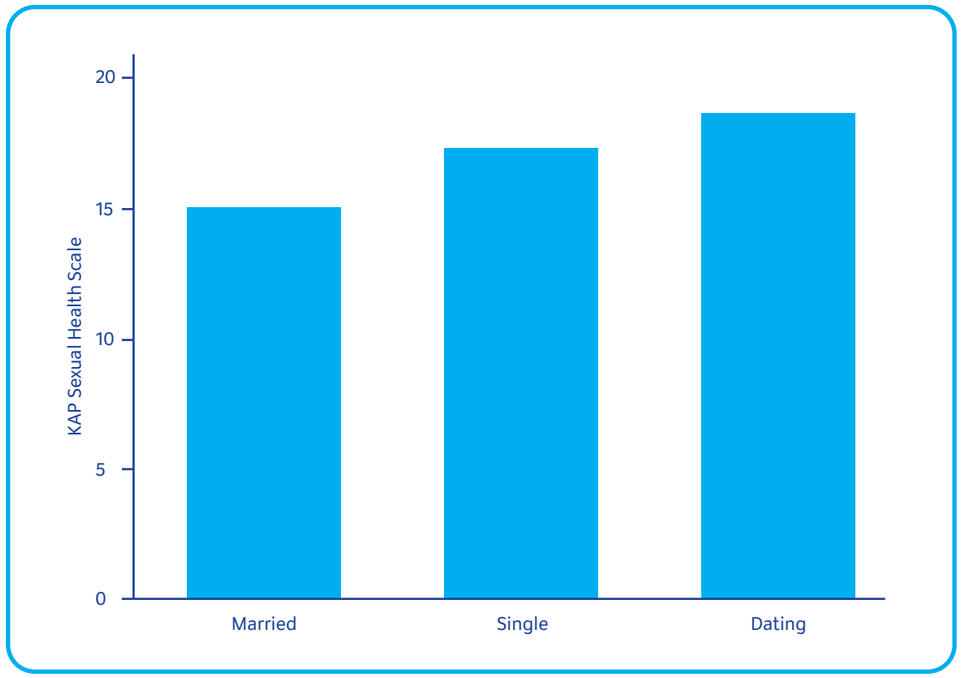
Graph 6: KAP Sexual Health Scale vs. No. of Sexual Partners



The mean level of KAP in sexual health is also determined by relationship status, with the lowest scores, on average, achieved by those who are married. KAP scores among those who are married were found to be significantly lower if compared with those who are just dating – at a coefficient of -2.67.

Significant differences in the mean KAP level were also detected for single and unattached young people compared with those who were dating. However, the difference in coefficient was considerably lower at –0.69. Graph 7 presents the mean value for each category.

Graph 7: Mean KAP Sexual Health Scale by Relationship Status



At this point, the profiling of a young individual living in one of the 15 European countries with clear sexual health KAP limitations becomes more evident.

This is a non-virgin Eastern European young married male, aged 15 to 20 years, with a high number of sexual partners and limited access to sexual and relationships education – specific interventions are required to boost their attitudinal and behavioural patterns for sexual health.

This is also important considering surveillance studies that show that Eastern Europe is one of the regions most vulnerable to HIV/AIDS and STIs. As reported by the Eurosurveillance system (Lowndes 2002), "the countries of Eastern Europe continue to experience some of the highest rates of new HIV infections in the world".

Current sources of sex and relationships education

Significant statistical differences were also found for the young people's current source of sex education. In this case, even though "friends" are a highly cited source of sex education in the large majority of the countries, other sources reached a significantly higher level of mean KAP in sexual health.

A striking result was the widespread reliance on the Internet in Eastern European countries. With the exception of young people in Hungary, all the Eastern European nationalities said that they currently went online for their main source of sex education. This was most evident in Romania (40%), Lithuania (38%) and Turkey (37%).

Those in Turkey, Romania and Poland said that not only did they use the Internet now for their information, but that it had been their major initial source of knowledge as well. Hungary stands alone for young people relying on their parents both as their first and current sources.

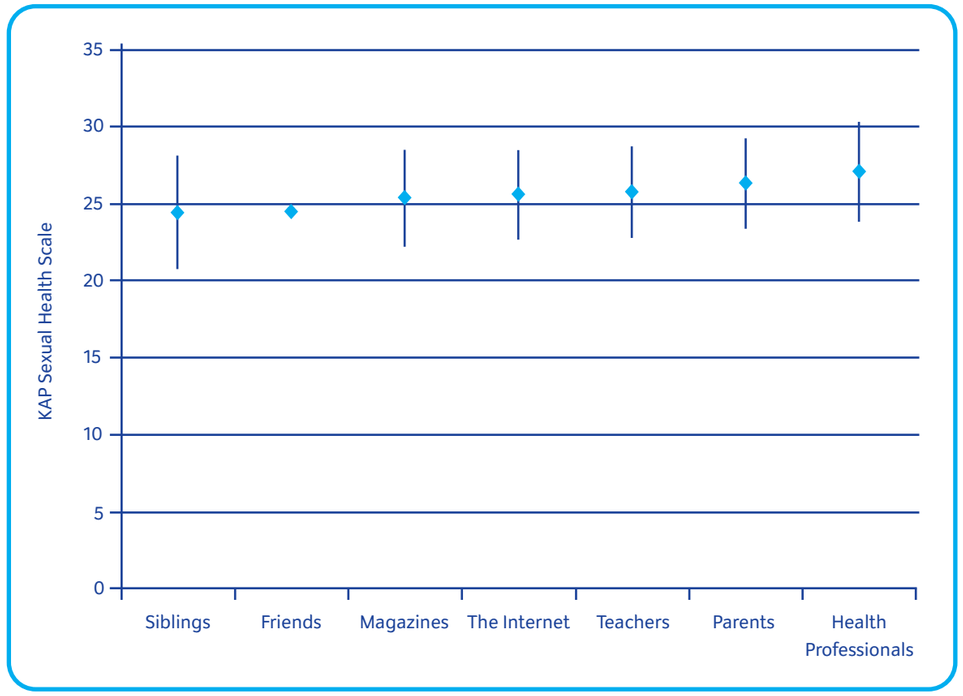
Although the Internet has huge potential to provide a mass audience with access to health information, there are reasons for concern. Studies such as Gerressu and French (2005) have highlighted how ascertaining the accuracy of the information is problematic, raising questions about the quality of the guidance it provides.

In comparison, only 13% of young people in France, 14% in Germany and 15% in Spain say that they currently go online for sexual health information – despite the widespread use of the Internet and social networking sites in those countries – and no Western European nationality cited the Internet as their main initial source.

Western European young people are more likely to look to parents or teachers for their knowledge. More than a third of those in Belgium (36%), for example, cited teachers as their first source of sex education, as did 30% in Spain. Meanwhile, parents were credited by 32% of the Dutch, 31% of the French and 30% of the Swiss.

The ranking of the main sources of sex education and their respective scores in the sexual health KAP scale are presented in Graph 8. Except for siblings, all other sources of sex education resulted in significantly higher scores in KAP, adjusting for all other variables included in the final robust regression model.

Graph 8: Sources of Sex and Relationships Education



The two main sources of sex education that result in the highest level of KAP were health professionals and parents.

Health professionals achieved the highest coefficient (2.6) of all other sources included in the final study, followed by parents (1.85). Teachers also reached a significant difference compared to friends, with a coefficient of 1.31.

However, there is a clear contrast when comparing these sources with the highest level of exposure. Even after combining doctors and nurses as one specific current source of sex education, the proportion of young people citing them as a main source of sexual knowledge is significantly lower than the Internet, friends, and even magazines. This is also similar for parents and teachers, which are ranked below the Internet and friends in a number of countries surveyed.

Young people in France are the most likely to gain their sexual health information from a doctor or family planning nurse – with 13% naming these as a major current source of education – followed by Hungary (12%) and Slovenia (10%). In contrast, among the Dutch, it was just 1%.

In the case of health professionals and better access to health services, according to Milne and Chesson (2000), "young people's health is giving rise to increasing concern. However, despite recent government emphasis on patient involvement and partnership, little discussion has occurred concerning how this may be achieved with younger age groups in primary care." Also, according to the authors, health care services are not considered by many young people, especially males, to be an attractive environment for health promotion or using language that relates to them.

Therefore, based on these findings, it can be seen that the key role of health professionals in providing young people with proper sexual health guidance can be significantly improved if some specific "demand-driven" and health promotion interventions are developed.

The importance of parents being involved in the sex education of their children has been widely reported, but few people really know how to tackle the issue in practice. In 2008, the Durex Network developed a statistical model that clearly demonstrated the strong association between the involvement of parents/guardians in the sex education of their children and the higher sexual confidence this brought the young people in later life.

This remains true even though friends/peers were given as the main source of sex education by a large number of respondents, with parent/guardians ranked as only the 8th most cited overall. For higher levels of sexual confidence, the influence of friends/peers is not statistically significant if compared with no main source of sex education.

Despite their low ranking overall, parents have played an important role in a number of the countries included in this research and were highest sources of initial information in France, Hungary, the Netherlands, Slovenia and Switzerland.

From an in-depth review of the literature and programme reports, it becomes clear that there is still a long way to go in understanding and evaluating the impact of parental involvement in sex and relationships education around the world and in identifying programmatic solutions.

For a better understanding, significant research efforts are required to find out more about the main obstacles and opportunities that parents face when their involvement is sought.

Most of the research in the scientific literature explores the extent of the need for parental involvement by interviewing teenagers through sexual behaviour surveys. In most of these studies, results show that teenagers are eager to see their parents involved, even though they, themselves, may create significant obstacles for an open dialogue with their parents and guardians.

Normative taboos, such as "what my friends will think of me" and "my parents are outdated on the subject of sex", may represent significant psychological "costs" to teenagers and contribute to the significant silence on this issue at home.

Finally, in the case of teachers and the education system, Bleakley et al (2009) found that although there is much debate on the best approach to sex education in schools, it is important that teachers are adequately equipped to deliver factual and relevant information. In addition, the 2010 Durex study with the NAHT, NCPTA and NGA found that 80% of UK school leaders did not feel trained and confident to talk about sex and relationships education. Only 9% rated their current teaching materials as very useful.

It is interesting to note that over 46% of young people in the UK cited teachers as their source of first sexual health information, a clear 10 percentage points higher than the next country, Belgium. This highlights firstly the significance of ensuring teachers are suitably equipped but also the need to embrace other sources to ensure young people are not relying on one major source for good sexual and reproductive health knowledge.

In sum, the issue of parental involvement, the change of language paradigms for health professionals and building the capacity of teachers should be better represented in scientific forums, such as sexology, reproductive health, and HIV/AIDS conferences.

It should also involve more resources and the identification of successful examples of intervention. And, it must mobilise institutions representing parents/guardians, teachers and health professionals to help them act as agents of social change and health promoters in their own homes, school environment, and the health system.

I've not had any formal sex education. It's not taught in schools here in Romania and it's left to parents to discuss it with their children, but my parents have split up and I have never really talked to my mother about it. I would feel too embarrassed. So I've really just learnt all I know from friends who have had sex and have shared their experiences with me. I'm still a virgin and I hope I have the knowledge I need if I should meet the right boy.

Female, 18, Romania

Conclusion

This study represents an overview of the levels of Knowledge, Attitudes, and Practices of sexual health among young people in several European countries.

The analysis of the data demonstrated that different levels of KAP in sexual health can be identified and some specific factors (sex education and specific sources of sex education) can have an effect in determining variations in KAP levels.

The results of the study highlight the importance of empowering health professionals, parents, and teachers in sex education targeted at youth.

As previous *Face of Global Sex* reports have demonstrated, this study shows that levels of exposure are not necessarily associated with higher levels of sexual health confidence and KAP.

The 2008 edition of the *Face of Global Sex* (The Path to Sexual Confidence), demonstrated that friends and peers are the ones most cited as the main source of sex education by respondents. Nevertheless, once a multivariate regression model is developed over different levels of sexual confidence and KAP for sexual health, the sources mostly associated with positive results are parents/guardians and health/education professionals.

The international literature and empirical evidence also reinforce this finding. For example, Stone and Ingham (2003) found that when parents portrayed sexuality in a positive manner during childhood it led to their children using contraception when they first had sex.

Several studies – such as those by Bleakley et al (2009), Dodge et al (2005), Aspy et al (2007) and Crosby, Hanson and Rager (2009) – present the significant impact of parent-child or parent-youth sex education interventions. There is clearly potential for programmes to be developed which provide fathers with suitable tools to engage positively with their children on sexual health matters. This is also true in the case of exposure to sex education efforts led by health professionals in different parts of the world.

The findings show that the number of young people referencing parents and health professionals as their main source of sex education is low in the large majority of countries surveyed and that, while there are many youth-led peer-to-peer mobilisations globally, there is no network for the role of parents and health workers. As a result, there are still significant gaps in engaging parents and health professionals. A change in public policy priorities and funding mechanisms may be required to reduce this important gap.

The study also demonstrates that early sex education and lower number of sexual partners are determining factors for higher levels of KAP in sexual health.

Some families and school settings are still concerned that early sex education may lead to early sexual initiation and higher numbers of sexual partners. In fact, the empirical evidence in the international literature shows an opposite trend. According to a review of the literature conducted by Kirby (2010), 37% of the studies on exposure to sex education among young people indicate that sex initiation was delayed. In addition, 44% of the studies showed a decrease in the number of sexual partners and 40% reported an increase in the use of contraception. For the remaining, no impact was found, and negative effects were unrepresentative.

My parents tried talking to me about sex but not much. It was a bit awkward when they did and I told them I knew it already, so they left it. Our sex education sessions at school were provided by Y-Peer, the Youth Peer Education Network that works with young people in lots of countries. It was good, much better than I'd expect teachers would have handled it. I was about 14 when we had the initial sex education session and I was pretty confident by the time I first had sex at the age of 17. I've had three more sexual partners since then and of course I have used a condom every time. I feel very comfortable with my sex life.
Male, 19, Bulgaria

Finally, young males should have more access to sex education programmes that address specific male roles in sexual health. As demonstrated in this report, their level of knowledge in sexual health is significantly lower in comparison to young females. This, in turn, has a direct impact in their sexual health attitudes and behaviours, such as the lack of condom use.

Several studies conducted by Instituto PROMUNDO in Brazil have demonstrated that young males are the ones most vulnerable to STIs. Furthermore, young males who are not sensitive to gender equality norms and behaviours are the ones most likely to avoid using sexual health services at the community level and to be exposed to violence.

In summary, there is not just one major factor that can be associated to higher levels of KAP in sexual health. The socio-economic and exposure factors that will determine how a young person will be able to absorb sexual health content and translate into attitudes that in turn will shape their safe-sex behaviours are multiple and complex. It will also depend on geographical factors and public policies that are promoted by their respective countries.

However, the Durex KAP Sexual Health Scale represents an important contribution to identifying some of these key factors and promoting scientifically informed programme planning and policy development.

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Appendix 1

Country	Ever had sexual intercourse %		Mean number of sexual partners	Age at first sex education	Woman can become pregnant the first time she has sexual intercourse %		
	No	Yes			Agree	Disagree	Don´t know
Austria	27.0	73.0	4.4	11.5	88.1	8.7	3.2
Belgium	36.8	63.2	3.0	11.7	91.1	6.9	2.0
France	34.4	65.6	3.8	13.1	92.9	4.9	2.2
Germany	19.6	80.4	4.7	12.1	79.5	17.2	3.3
Hungary	25.8	74.2	3.3	12.0	93.1	4.6	2.3
Italy	30.5	69.5	3.9	15.3	74.9	20.9	4.2
Lithuania	42.5	57.5	2.9	13.2	88.3	8.2	3.5
Netherlands	29.6	70.4	3.6	12.1	91.6	7.3	1.1
Poland	42.9	57.1	2.5	12.9	93.2	4.8	2.0
Romania	31.4	68.6	3.6	14.3	84.9	11.2	3.9
Slovenia	34.4	65.6	3.0	11.5	88.5	8.9	2.6
Spain	26.5	73.5	3.9	14.8	81.0	15.9	3.1
Switzerland	34.4	65.6	4.0	11.9	86.7	11.6	1.7
Turkey	36.9	63.1	5.3	14.9	66.7	27.1	6.2
United Kingdom	33.2	66.8	4.0	11.9	91.7	5.7	2.6

Country	STIs can be transmitted %				
	Blood donation/ transfusion	Using public toilets	Through kissing	Unprotected sex between a man and a woman	Unprotected sex between men
Austria	85.9	26.9	16.0	98.1	85.1
Belgium	89.6	19.2	24.6	98.5	90.1
France	87.2	18.0	14.3	98.3	94.0
Germany	87.2	28.8	17.9	97.3	82.5
Hungary	88.9	40.2	27.6	96.2	87.7
Italy	86.3	33.8	24.2	96.0	80.6
Lithuania	91.4	30.7	29.0	98.1	74.4
Netherlands	86.4	22.9	26.3	99.3	95.0
Poland	87.9	24.9	16.8	98.1	80.4
Romania	92.4	40.3	25.4	97.8	76.7
Slovenia	86.8	29.4	24.1	98.0	83.9
Spain	88.4	27.9	26.5	98.3	89.5
Switzerland	86.0	21.4	13.6	97.3	88.0
Turkey	86.6	44.4	46.9	90.5	56.4
United Kingdom	87.9	24.5	25.1	97.5	92.5

Country	How much risk of STIs %					Using condoms with a new partner is a smart idea %				
	No risk at all	Little risk	Don’t know	Moderate risk	Great risk	Totally agree	Agree	Neither	Disagree	Totally disagree
Austria	18.8	32.5	3.3	34.6	10.8	89.1	8.5	1.6	0.0	0.8
Belgium	23.2	47.1	5.5	19.2	5.0	83.5	14.1	2.0	0.1	0.3
France	23.3	28.9	11.0	20.7	16.1	84.5	11.3	3.3	0.3	0.6
Germany	22.3	22.8	4.9	30.5	19.5	87.0	8.6	3.1	0.4	0.9
Hungary	39.0	36.2	6.6	15.1	3.1	83.3	12.8	3.0	0.4	0.5
Italy	24.3	34.7	5.0	26.7	9.3	78.5	15.9	4.4	0.3	0.9
Lithuania	45.2	30.8	3.8	13.0	7.2	78.5	16.6	2.8	0.7	1.4
Netherlands	27.8	48.7	4.5	15.1	3.9	83.9	14.6	0.9	0.4	0.2
Poland	53.1	32.5	2.2	9.6	2.6	77.4	17.2	4.0	0.9	0.5
Romania	44.1	31.0	5.8	10.3	8.8	81.5	11.3	4.5	1.6	1.1
Slovenia	23.3	33.8	5.4	25.9	11.6	89.0	9.2	1.0	0.6	0.2
Spain	36.1	47.9	4.2	9.0	2.8	84.3	10.7	3.4	0.8	0.8
Switzerland	18.0	34.7	4.0	31.3	12.0	88.2	8.9	2.4	0.1	0.4
Turkey	39.4	22.6	8.8	14.1	15.1	68.2	19.4	6.5	2.2	3.7
United Kingdom	37.7	42.1	3.2	12.9	4.1	84.5	12.8	2.2	0.2	0.3

Country	Using condoms is not necessary if you know your partner %					Easy to discuss using condoms with a prospective partner %				
	Totally agree	Agree	Neither	Disagree	Totally disagree	Totally agree	Agree	Neither	Disagree	Totally disagree
Austria	7.6	14.8	29.2	27.8	20.6	39.7	27.5	25.9	5.6	1.3
Belgium	3.4	13.6	31.3	32.2	19.5	21.1	36.1	28.0	12.6	2.2
France	4.2	11.0	23.2	33.8	27.8	22.2	29.9	27.7	17.2	3.0
Germany	7.9	14.7	33.0	26.2	18.2	42.5	30.9	20.1	5.3	1.2
Hungary	5.4	9.8	29.9	34.5	20.4	20.2	31.8	30.9	14.6	2.5
Italy	5.7	14.4	30.0	30.5	19.4	24.7	34.4	28.0	10.1	2.8
Lithuania	6.1	18.6	23.7	34.2	17.4	21.3	29.8	34.3	11.3	3.3
Netherlands	2.8	10.9	31.0	37.6	17.7	21.6	35.6	26.9	13.1	2.8
Poland	3.1	16.1	25.9	37.1	17.8	15.0	32.2	33.6	16.7	2.5
Romania	5.6	18.4	22.1	33.1	20.8	29.8	39.5	24.4	4.0	2.3
Slovenia	4.3	13.8	28.1	31.3	22.5	29.7	34.5	26.3	8.4	1.1
Spain	3.9	10.4	23.2	32.0	30.5	34.6	28.7	26.2	8.3	2.2
Switzerland	6.5	14.3	27.1	28.1	24.0	40.2	32.3	20.1	6.0	1.4
Turkey	22.0	21.6	20.6	21.7	14.1	34.1	28.7	22.9	8.3	6.0
United Kingdom	4.2	11.1	22.0	40.6	22.1	27.9	35.2	22.9	12.5	1.5

Country	Condoms diminish sexual enjoyment %					It is embarrassing to ask for condoms in family planning clinics or pharmacies %				
	Totally agree	Agree	Neither	Disagree	Totally disagree	Totally agree	Agree	Neither	Disagree	Totally disagree
Austria	12.9	16.7	33.1	18.9	18.4	7.1	13.3	16.8	20.9	41.9
Belgium	13.7	20.7	34.3	19.2	12.1	14.5	28.7	19.8	20.4	16.6
France	8.6	19.3	37.7	20.9	13.5	21.4	29.8	16.2	17.1	15.5
Germany	20.4	19.1	31.6	15.5	13.4	10.7	11.5	16.7	19.1	42.0
Hungary	16.5	23.6	28.5	21.4	10.0	7.9	15.3	21.8	27.6	27.4
Italy	16.3	23.2	30.6	19.7	10.2	6.6	11.0	17.4	24.0	41.0
Lithuania	13.8	21.4	34.6	19.9	10.3	11.0	20.6	22.1	20.0	26.3
Netherlands	11.8	24.7	33.7	20.8	9.0	7.9	25.4	20.7	20.7	25.3
Poland	9.4	18.9	43.2	22.2	6.3	7.5	19.2	20.2	30.4	22.7
Romania	13.9	23.0	33.4	21.3	8.4	8.7	13.1	17.3	26.0	34.9
Slovenia	16.0	21.6	30.5	21.4	10.5	8.6	15.2	16.5	29.4	30.3
Spain	11.5	21.8	34.3	19.2	13.2	16.2	24.0	17.9	17.8	24.1
Switzerland	10.8	18.9	32.0	22.0	16.3	7.6	15.4	21.0	21.9	34.1
Turkey	33.5	24.5	22.2	10.8	9.0	30.6	18.7	12.6	13.8	24.3
United Kingdom	9.6	18.9	38.3	24.5	8.7	16.7	31.9	16.9	21.8	12.7

Country	Sex education gives adolescents the idea to begin sex earlier %					Sex education should be taught only at home %				
	Totally agree	Agree	Neither	Disagree	Totally disagree	Totally agree	Agree	Neither	Disagree	Totally disagree
Austria	8.6	14.5	27.8	26.0	23.1	3.0	4.0	12.8	31.0	49.2
Belgium	4.8	12.1	26.4	35.6	21.1	1.4	2.1	8.7	36.7	51.1
France	7.8	14.1	24.4	32.5	21.2	2.4	4.4	19.3	42.4	31.5
Germany	13.9	16.4	31.7	25.8	12.2	3.8	5.9	20.5	31.1	38.7
Hungary	10.3	15.6	26.1	32.2	15.8	5.0	6.8	16.9	41.0	30.3
Italy	10.6	15.1	26.6	28.4	19.3	1.9	3.6	11.3	36.3	46.9
Lithuania	8.9	20.5	25.0	31.6	14.0	3.8	8.2	15.2	41.8	31.0
Netherlands	4.3	12.8	24.4	37.3	21.2	2.8	5.5	13.9	44.3	33.5
Poland	5.0	14.4	27.3	39.1	14.2	8.1	30.2	30.0	21.5	10.2
Romania	9.8	13.5	23.4	34.5	18.8	6.0	8.0	10.7	43.1	32.2
Slovenia	8.8	12.5	25.1	32.8	20.8	3.8	3.3	12.8	34.8	45.3
Spain	10.9	16.7	23.1	25.1	24.2	2.1	3.2	11.1	31.7	51.9
Switzerland	9.1	13.1	24.9	30.4	22.5	3.7	4.1	10.9	35.1	46.2
Turkey	38.7	21.2	14.8	9.0	16.3	16.8	11.0	16.2	20.7	35.3
United Kingdom	9.4	22.0	20.9	32.8	14.9	2.7	4.2	13.8	44.8	34.5

Country	Sex education goes against my religious beliefs %					Teachers do not have enough training for sexual education %				
	Totally agree	Agree	Neither	Disagree	Totally disagree	Totally agree	Agree	Neither	Disagree	Totally disagree
Austria	2.4	1.7	6.6	13.4	75.9	25.6	27.7	28.6	10.0	8.1
Belgium	1.9	2.3	6.9	22.8	66.1	13.9	30.9	31.1	16.0	8.1
France	2.2	3.4	11.6	30.0	52.8	11.6	25.0	31.3	21.8	10.3
Germany	5.9	3.7	17.3	18.8	54.3	24.8	28.2	30.8	11.2	5.0
Hungary	11.9	13.6	9.9	22.2	42.4	14.3	26.1	30.9	20.2	8.5
Italy	1.8	2.4	8.0	21.3	66.5	21.4	26.1	28.3	13.9	10.3
Lithuania	3.3	3.1	9.8	27.0	56.8	26.3	34.1	17.2	15.1	7.3
Netherlands	0.9	2.1	9.2	21.2	66.6	13.0	37.6	32.5	12.4	4.5
Poland	2.1	4.5	15.0	31.7	46.7	33.2	33.3	21.0	10.2	2.3
Romania	4.6	3.6	10.0	29.2	52.6	22.9	31.0	22.8	17.0	6.3
Slovenia	2.0	2.3	4.8	25.8	65.1	16.8	22.0	32.6	17.6	11.0
Spain	2.1	1.8	8.3	18.6	69.2	18.4	30.4	31.5	12.5	7.2
Switzerland	2.4	2.9	9.4	16.3	69.0	24.8	29.5	26.1	13.2	6.4
Turkey	17.8	11.2	18.5	15.9	36.6	50.6	22.5	11.3	5.3	10.3
United Kingdom	3.5	3.8	9.4	26.8	56.5	13.0	29.6	24.8	21.0	11.6

Country	Would you use a condom during first sex with a new partner %			Have you ever used condoms for...%					
	Yes	No	Maybe	Birth control only	Both	Disease prevention only	Not sure/ do not remember	Used condom out of curiosity	Never used a condom
Austria	88.6	2.3	9.1	9.7	70.1	6.4	2.8	1.2	9.8
Belgium	82.0	2.0	16.0	11.8	56.2	4.7	4.9	2.3	20.1
France	91.5	2.2	6.3	4.4	71.2	5.9	3.5	0.7	14.3
Germany	84.2	3.0	12.8	10.8	70.1	7.7	2.4	1.6	7.4
Hungary	90.2	2.2	7.6	20.1	55.6	5.0	4.6	0.7	14.0
Italy	88.2	2.0	9.8	15.5	63.6	3.9	2.2	1.2	13.6
Lithuania	87.8	2.7	9.5	21.0	52.5	1.6	4.6	2.0	18.3
Netherlands	84.9	2.1	13.0	9.0	59.9	6.7	4.6	1.7	18.1
Poland	83.4	3.5	13.1	16.4	51.8	2.8	7.9	2.6	18.5
Romania	89.9	3.4	6.7	11.6	67.2	5.9	7.7	1.3	6.3
Slovenia	91.9	0.7	7.4	16.5	62.5	3.4	4.5	1.0	12.1
Spain	94.5	1.0	4.5	8.9	68.7	4.0	1.5	0.3	16.6
Switzerland	93.7	1.4	4.9	10.2	67.8	5.7	1.9	1.7	12.7
Turkey	60.7	14.4	24.9	14.2	44.0	12.0	6.6	2.7	20.5
United Kingdom	86.7	2.5	10.8	9.6	54.2	2.5	9.6	3.3	20.8

Country	Used any form of contraception during last sexual intercourse %			Used condoms the last time had sexual intercourse %		
	Yes	No	Don’t know/cannot remember	Yes	No	Don’t know/cannot remember
Austria	80.3	16.6	3.1	64.5	33.2	2.3
Belgium	77.6	18.3	4.1	51.7	45.4	2.9
France	78.6	18.9	2.5	65.0	33.6	1.4
Germany	74.9	22.4	2.7	61.5	36.3	2.2
Hungary	51.3	45.4	3.3	59.2	39.3	1.5
Italy	52.4	43.9	3.7	68.5	29.4	2.1
Lithuania	49.2	45.2	5.6	71.8	24.9	3.3
Netherlands	80.3	17.5	2.2	49.7	48.1	2.2
Poland	70.4	26.0	3.6	68.3	29.3	2.4
Romania	74.7	20.0	5.3	71.9	25.1	3.0
Slovenia	75.0	20.7	4.3	63.9	34.0	2.1
Spain	76.7	18.8	4.5	78.7	19.7	1.6
Switzerland	81.8	15.3	2.9	73.8	24.8	1.4
Turkey	58.4	37.4	4.2	58.6	37.8	3.6
United Kingdom	78.3	18.9	2.8	55.9	42.0	2.1

Country	Source of first sexual health information %									
	Brother/ sister	Church/ religious leader	Doctor	Family planning nurse	Friends	Government	Magazines	Parents	Teachers	The Internet
Austria	2.8	0.1	4.0	0.0	16.9	0.8	12.7	25.3	26.5	10.9
Belgium	3.5	0.1	2.0	0.5	19.8	1.7	5.4	18.1	35.9	13.0
France	2.7	0.2	5.0	9.2	13.5	2.6	5.3	31.7	20.5	9.3
Germany	2.4	0.4	4.8	0.5	21.8	1.8	8.5	24.5	29.0	6.3
Hungary	4.3	0.4	1.3	12.4	23.0	1.1	11.9	26.6	11.3	7.7
Italy	2.6	0.2	4.9	0.8	30.1	10.9	4.6	16.0	14.3	15.6
Lithuania	1.9	0.2	2.7	0.4	18.5	1.0	17.7	14.4	22.0	21.2
Netherlands	2.3	0.4	1.4	0.0	14.3	1.8	7.2	32.6	19.9	20.1
Poland	3.1	0.2	4.7	1.0	18.6	1.2	17.9	18.5	13.1	21.7
Romania	3.2	0.2	4.0	1.0	18.3	0.9	16.1	23.0	8.8	24.5
Slovenia	2.3	0.2	8.7	1.2	16.4	0.5	13.4	21.7	17.8	17.8
Spain	3.0	0.5	1.0	2.5	20.5	5.5	4.0	24.9	30.8	7.3
Switzerland	1.8	0.3	2.7	0.6	17.7	0.8	10.3	30.3	21.8	13.7
Turkey	7.9	0.4	3.5	1.1	33.2	2.4	1.3	8.6	9.4	32.2
United Kingdom	2.2	0.0	3.2	3.0	14.5	2.4	3.0	17.4	46.4	7.9

Country	Current major source of sexual health information %									
	Brother/ sister	Church/ religious leader	Doctor	Family planning nurse	Friends	Government	Magazines	Parents	Teachers	The Internet
Austria	3.1	0.1	2.3	0.0	20.9	1.3	10.8	15.6	27.6	18.3
Belgium	2.7	0.2	2.3	0.4	22.3	1.9	5.5	12.2	33.2	19.3
France	2.6	0.3	4.1	9.0	22.4	2.3	5.1	22.6	17.9	13.7
Germany	3.6	0.2	4.0	0.3	24.7	2.0	9.4	16.5	25.2	14.1
Hungary	2.1	1.3	1.3	10.7	25.6	0.8	7.0	31.9	7.2	12.1
Italy	2.3	0.1	4.4	1.2	31.2	11.7	4.6	15.0	10.0	19.5
Lithuania	1.7	0.0	3.7	1.5	18.3	2.3	14.4	10.2	9.6	38.3
Netherlands	1.8	0.0	1.4	0.0	14.7	2.2	5.7	26.9	24.9	22.4
Poland	2.8	0.3	3.5	1.9	16.5	2.1	15.9	14.0	14.3	28.7
Romania	1.6	0.2	4.0	1.2	20.5	0.3	12.2	16.3	3.1	40.6
Slovenia	2.1	0.2	8.9	1.9	15.9	1.1	13.8	16.0	13.9	26.2
Spain	2.5	0.3	1.7	3.3	27.2	6.1	3.8	21.5	18.4	15.2
Switzerland	1.6	0.3	2.1	0.6	17.9	0.6	8.6	15.6	33.4	19.3
Turkey	7.6	0.7	5.2	0.5	30.9	2.8	1.3	7.1	6.5	37.4
United Kingdom	2.4	0.3	2.7	4.3	20.5	3.0	4.4	11.0	32.3	19.1

Country	Sample size and margin of error per country	
	n	Margin of error %
Austria	1,032	3.0
Belgium	3,218	1.7
France	757	3.5
Germany	1,332	2.6
Hungary	653	3.8
Italy	1,365	2.6
Lithuania	691	3.7
Netherlands	627	3.8
Poland	750	3.5
Romania	856	3.3
Slovenia	731	3.6
Spain	685	3.7
Switzerland	1,291	2.7
Turkey	1,091	2.9
United Kingdom	689	3.7

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