Factors Influencing Low levels of Teenage Pregnancy in the Netherlands

A case study in Amsterdam City

By

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Dedication

For my parents: Mr. Patrick Bukuluki and Mrs Joyce Irima Bukuluki, and Prof. John Muzaale.

I explain why your term is mostly about sexuality while you are talking about factors influencing low level teenage pregnancy.

Struggle not ideas (see part 1) good objectives

Dis

help people conclude

Knowledge rules

more among boys than girls

Poor pressure

Telling about sex between boys and between girls

Boys have to have sex! They just want sex!
Acknowledgement

My thanks are due to my lecturers who in many ways helped me to accomplish this task. I am grateful to Dr. Anita Hardon my supervisor for her efforts to quality assure this thesis and for her valuable advice. Many thanks to Prof. S. Geest, Varkevisser, Trude and Ria Reis, Els and Streefland for their academic counsel. I am greatly indebted to my friend Ester, Sarah and Jessica, Christine, Tiseke and Maricel for all their assistance without which it would have been an uphill task to accomplish this research exercise. I would also like to extend my sincere thanks to all my informants without whose support and co-operation the whole research exercise would have been a boomerang. Most of all glory be to God without whose will I would never have started nor finished this thesis. Last but not least, thanks go to fellow AMMA students for their esteemed academic and moral support.
The risk of talking about sex with parents, because of risk of incest/peer for incest.

The issue in parents—
children communication;
is pregnancy avoidance—
not sexual pleasure.

Brothers and sisters are
special sub-group?
peers—
Could be a hypothesis.
Chapter One: Introduction

Study Synopsis
The major motivation for undertaking this study was to explore factors contributing to the low level of teenage pregnancies in the Netherlands. The study problematized both the service and socio-cultural factors that are contributing to the positive adolescent reproductive health situation in the Netherlands. In executing the study, the researcher largely employed ethnographic/qualitative methods. Sample selection was done purposively. Majority of the study participants were adolescents. In addition, parents, teachers, researchers and officials working with adolescent reproductive health projects were interviewed. These will basically play the role of key informants. Data collection was carried out using interview guide and observation checklists. Where applicable, projective techniques were applied. Thematic and content analysis were used to analyze the data collected. At the end of the study, the researcher had gained better understanding of the dynamics of teenage pregnancy in the Netherlands. This enabled him to draw some lessons that could be adapted to the socio-cultural climate and resource constraints of developing countries like Uganda, improve their adolescent reproductive health interventions.

Background to the Study
Young people's health has become a subject of increasing importance throughout the world. This is because of increasing appreciation of the importance of this age group to public health in the short and long term. There has also been a recognition that the changing environmental conditions and changing patterns of behaviour have increased health hazards for young people (WHO/ADH 1992:1). This is especially true with regard to the sexual and reproductive health of adolescents.

WHO/ADH (1992:1) aptly observed that in recent decades, population growth in developing countries, urbanization, the crossing of cultural boundaries by rapidly expanding telecommunications, early menarche combined with delayed marriage, and decline of extended family structures, have given rise to new patterns of sexual behaviour. Unprotected premarital sexual relations are taking place at earlier ages giving rise not only to problems of too early pregnancy and child bearing, but also to induced abortion in hazardous circumstances, to sexually transmitted diseases and to the contemporary scourge of immune-deficiency virus leading to AIDS. Problems of early sexual contact and adolescent pregnancy and motherhood are closely linked to the phenomena of STDs including HIV/AIDS.

UNFPA and UNAIDS reported that around half a million young people are infected with an STD every day. It is estimated that every year, 1 in 20 teenagers becomes infected with an STD. In addition, young people under the age of 25 account for half of all the HIV infections. It is also stated that every day, at least 4000 people under the age of 25 are infected with HIV, predominantly in south-east Asia and Sub-Saharan Africa.
Reproductive Health is central to human development. It implies that people are able to have a responsible, satisfying sex life, have the capability to reproduce and the freedom to decide, when and how often to do so (WHO/UNFPA, 1994). Germain and Ordway (1995) define a reproductive health approach as one which enables all women and men, including adolescents, to regulate their own fertility safely and effectively, by conceiving when they desire, terminating unwanted pregnancies and carrying wanted pregnancies to term; remain free of disease, disability or death associated with reproduction and sexuality; and to bear and raise healthy children.

The major premise of this conceptualization is that men and women, including adolescents, have the right to be informed of and to have access to safe, effective, affordable and acceptable methods of fertility regulation of their choice. This implies the right of access to appropriate health services to all without discrimination based on age, race, and class. Reproductive health is an essential prerequisite for the health of all people, including infants and children, adolescents and even people beyond reproductive years.

The researcher has adopted the WHO definition of adolescence which stipulates that it is the period between 10 and 20 years. WHO (1992) stipulates that adolescence is a period characterized by:

- rapid physical growth and development;
- physical, social and psychological maturity, but not all at the same time;
- trying out sexual experiences for the first time;
- frequent lack of knowledge and skills to make healthy choices;
- patterns of thinking in which immediate needs tend to have priority over long term implications;
- the start of behaviours that may become long term habits that result in diseases many years later.

One in every four to five people in the world is an adolescent and 85 in every 100 adolescents live in developing countries (WHO 1996). Young people of this age group make up to 29% (1:3) of the total population in developing countries and 21% in developed countries. By 2025, there are expected to be almost 2 billion people in this age group (UNFPA-Generation 97:16). In Sub-Saharan Africa, it is estimated that 8 out of 10 young people below the age of 20 are sexually experienced and at least half of all teens in Latin America (Ibid:16). According to the same documentary, one in every 10 births world-wide is to a teenage mother. In West Africa and South Asia, around 50% of the young women have a child by the age of 20. In the least developing countries, the proportion of births to adolescents is over 17%, and in at least one area- Middle Africa, it is almost 24%.

Conversely, in Europe, countries like the Netherlands, Germany and France are reported to have better public health outcomes. Their youth delay the onset of sexual activity longer than do the youth in developing countries as well as some developed countries like the United States (Berne and Huberman 1999:ix). Teenage pregnancy rates are therefore
relatively low in these countries. The teenage birth rate in the Netherlands, for example, is nearly eight times less than in the United States and far less than the teenage birth rate in most (if not all) developing countries (ibid:1999:ix).

The epidemic proportion of teenage pregnancies in developing countries is worrying as early pregnancy carries many health risks. Research has aptly established that girls aged 10-14 are 5 times more likely to die in pregnancy or child birth than women aged 20-24. Early child bearing is a threat to women’s educational, social and economic status in all parts of the world, but more especially in the developmentally challenged countries. Early motherhood not only entails an enlarged risk of maternal death but also the children of young mothers have higher levels of morbidity and mortality (WHO Safe Motherhood magazine 1996).

In a similar manner, it has been established that pregnant adolescents are more likely to suffer eclampsia and obstructed labour than women who become pregnant in their early 20s. A particularly devastating complication of obstructed labour is obstetric fistula, a hole between the vagina and the bladder or rectum. The woman constantly leaks urine or feces, smells offensive and is often ostracized both by her husband and by the community. Studies from Africa and Asia show that adolescents having their first baby are much more likely to suffer obstetric fistula than older women giving birth for the first time.

WHO (1996) unraveled that babies born to young adolescent mothers are more likely to have low birth weight, run a high risk of being premature and have a higher rate of prenatal mortality. Around the world, unwanted pregnancies cause distress among adolescent girls and their families alike. Even wanted pregnancies in places where girls marry very young can be a threat to the health of the adolescent mother and her baby. In a similar vein, the WHO Safe Motherhood Newsletter (Issue 1996) has estimated that every year nearly 15 million adolescents under the age of 20 give birth, although many may have had no intention of doing so. Surveys in developing countries show that between 20% and 60% of the pregnancies and births to women under the age of 20 are mistimed or unwanted. Similarly, girls who become pregnant in their teens are less likely to seek prenatal care than older women despite the fact that they are more likely to have reproductive health problems than women over 20.

It is imperative to note that in cultures where early marriage is common, adolescent pregnancy is generally welcomed by the family, if not always by the adolescent girl (WHO, 1996). However, if the pregnancy occurs outside marriage, social sanctions may be severe and induced abortion may seem to be the only way of avoiding public shame and rejection. Adolescents account for a very high proportion of abortion complications primarily because they are likely to obtain clandestine illegal abortions, or to delay seeking abortion until late in the pregnancy (WHO 1996:6). In most of the third world countries, abortion is illegal, this has hindered the development of abortion services and has put at risk the life of most adolescents who due to high levels of stigmatization, see abortion as the only method accessible to them. This is a challenge to many developing
countries because knowledge, attitudes and practices towards abortion are still quite poorly developed in these countries.

There is cultural relativity in the ways different families react to adolescent reproductive health issues, some of which just aggravate their reproductive health problems. For example, although there is an increasing recognition that young people face a longer period of time before marriage during which they are sexually mature and may be sexually active, sexual activity may be neither desired nor socially acceptable in these societies. This creates tensions and may result into self destructive behaviour among pregnant girls.

Another salient issue is that even if a pregnant adolescent is physically developed, she may lack the social and emotional maturity to cope with the experience of becoming a mother and the changes it means in her life. Worse still her male partner, if he is an adolescent, is also not likely to be able to shoulder the responsibilities of fatherhood. The crux of the problem arises from “children having children”. A young adolescent mother barely out childhood herself and certainly not an adult (liminality), may not have the parenting skills to bring-up a physically and mentally healthy child.

Unmarried pregnant adolescents may run a risk of being rejected by family and community. For young mothers overall, early motherhood can severely curtail their educational and employment opportunities with long term adverse effects on their and their children’s quality of life (WHO, 1994). For example in Uganda, adolescents who have babies are often unable to continue their schooling.

In fanatic Christian families, these adolescents are ostracized and rejected by the parents, relatives and friends. A young woman with a baby has less chance of finding employment and if she has not yet completed her education, this will be an added disadvantage. Also chances of marriage are likely to be reduced. She is most likely to live in absolute poverty. Poverty and poor health often go hand in hand and reinforce the effects of each other. This may lead to web of interlocking disadvantages of vulnerability, physical weakness, isolation, powerlessness and poverty (Chambers: 1987), which combine to render the adolescent mother even less able to cope. Therefore the life tasks placed upon teenage pregnant adolescents and mothers may in most cases be beyond their coping capacities.

Looked at from a broad perspective, early pregnancy has negative consequences not only for the mother and baby, but also for the community (WHO Newsletter 1996:6). A poor unmarried mother with little education is not only unable to contribute to development of the community, but she and her family exacerbate the dependency ratio a country. It is in the community’s interest that all families irrespective of whether they are two or “more” parents or single parent to be economically viable and adolescent pregnancy certainly is a hazard to this at any given time. Similarly, girls who become pregnant in their teens are less likely to seek prenatal care than older women despite the fact that they are more likely to have reproductive health problems than women over 20.
Owing to the a fore presented/ discussed magnitude of the adolescent reproductive health problems ranging from early unprotected sexual encounters, high prevalence of teenage pregnancies, sexual exploitation to high levels of STDs, including HIV/AIDS in developmentally challenged countries, teenage pregnancy has come to the fore of research in both developed and developing countries.

2.1 Variations in Reproductive Health between Netherlands and other countries in the North

It is noteworthy that countries in the North, especially the Netherlands are experiencing very low levels of teenage pregnancy. The Netherlands has a population of 15.5 million people of whom 3.5 million are women of child bearing age (15-44 years). About 16% are immigrants, mostly from Surinam, the Dutch Antilles, Turkey, and Morocco (Central Statistics Office, 1996). Delbanco and Lundy (1997:3) in their article published in the Family Planning Perspectives Magazine (1997) stipulated that the Netherlands has the lowest proportion of unplanned pregnancies (6%) among the western nations. The United states was reported to have the highest rate (94.8 pregnancies per 1000), Canada (72.0 per 1000). In addition, the variation in the unplanned pregnancy among these countries is strikingly reflected in the disparity in abortion rates.

According to Delbanco, Lundy and Janet et al (1997:3-4), the overall U.S. abortion rate (25.9 abortions per 1000 women aged 15-44) is 1.7 times that of Canada (15.3 per 1000) and more than four times that of the Netherlands (6.0 per 1000). It is claimed by Delbanco et al (1997) that the three countries health care systems undoubtedly contribute to the disparity in rates of unplanned pregnancy and abortion through dissimilar levels of access to contraceptive services, approaches to sexual education and sources of information about pregnancy prevention. However, in this study, more emphasis was put on variations based on service factors. Little attention was given to the role of socio-cultural like socialization, as well as the dynamics of relationships between men and women.

As elucidated above, there exists some variation among Northern countries with regard to the incidence of teenage pregnancies and abortion. However, there is even an overwhelming variation between most Northern and Southern countries in the incidence of teenage pregnancies, abortion and STDs. This has led to numerous discussions and to the recommendation that research done in the north could complement research done in the south by allowing the findings to be contrasted and compared on a large, international scale. It is partly because of this recommendation that the researcher was motivated to undertake this research.

According to Hartmann (1987), a clear distinction seems to be emerging between developed and developing countries with regard to control over reproductive choices. She noted that whereas people in industrialized countries have the right to voluntary choice as to whether and when to bear children, in developing countries this right is subordinate to
the overriding imperative of population control. Women in the north have better control over their own reproduction and have access to high quality reproductive services in comparison to their counterparts in developing countries. What has not been well problematized however, is the factors that motivate women in developed countries to have better control over their reproduction. It could be that even if women in developing countries would have access, there are other factors that could act as barriers to their utilization of reproductive health services. This made it fascinating for the researcher to examine the socio-economic and cultural factors contributing to this desirable state of reproductive health, most especially the low teenage pregnancies in the Netherlands.

It is noteworthy that learning more about reproductive views and practices in the north could help researchers and women health advocates from the “Northern countries” to put southern developments in the field of reproduction into perspective and avoid ‘selective judgments’. At the same time, it is useful for their counterparts in the south to ‘know more about the situation in the industrialized world in order to confront the north with its own ethnocentric prejudices’. By knowing more, they can become more skeptical of the ideal image of the north which, too often, is presented to them in international discussions (Hardon and Sciortino 1994:10). It was with such consideration that it was decided to undertake a study to unravel the factors that are influencing the low teenage pregnancy levels in the Netherlands.

Not withstanding the above discussion, it is worthy to note that there are some differences in the perception of pregnancy planning in the North among health professionals and some social policy analysts such as Charles Murray. The difference is basically that for health professional, the problem with teenage pregnancy is that most of them are unplanned; for Murray and his contemporaries; it is that they are planned so as to gain access to council housing and welfare (Murray 1990).

In a similar concern, James and Gabe (1996) contend that, given the problematic character of teenage pregnancy, it is defined by health professionals in terms of a dichotomy between planned and unplanned pregnancy. It is not surprising that health services researchers tend to emphasize the cognitive and to a lesser extent the situational and social factors that prevent teenagers, usually the female from making rational decisions about having sex and the use of contraception.

There is however, some growing recognition among health service researchers that this emphasis on cognitive to the exclusion of the effective (social and situational factors) may be problematic. For example, Cheetham (quoted in James and Gabe 1996: 82): stated that:

"This is a complicated and muddled world where unplanned pregnancies may be wanted, where wanted children may emerge from unwanted pregnancies, where offspring of wanted pregnancies may be rejected. Where infatuation with infants
grows cold and where children may be wanted solely for their parents pathological needs.”

Given these uncertainties, some researchers prefer the phrase unintentional pregnancy to unplanned pregnancy. Peckham (1992:7) wrote that; whilst it is difficult to define what is meant by unplanned or unwanted pregnancy it is generally accepted to be beneficial to try and reduce such pregnancies. It is imperative to note that it is possible to discern an implicit recognition of the role of social factors like emotion in the discussion of aspects of the youth culture which militates against planned sexual activity. For many young people planned or premeditated sex combined with an expectation of contraceptive use is equated with low sexual morals (Peckham 1992:23, Phoenix 1991, Hudson and Ineichen 1991).

McRobbie (1978:98-9, in James and Gabe 1996) aptly stipulated that according to the code of romantic love in the culture of working class girls in England, it is not acceptable for a young woman to desire or plan to have sex: having sex is only acceptable if you are in love and ‘get carried away’. For a young woman to be on the pill or carrying condoms would be to risk criticism since such calculated, predetermined action totally contravenes the dominant code of romance.

Further more, Wight (1992:15), who was a sociologist working on HIV-related risk behaviour is cited by James and Gabe (1996) to have commented that: “ this code makes it desirable for some women to fall pregnant through unpremeditated sex than to go on the pill and be labeled promiscuous. Lee (1986, 1992) cited by the same authors argues that: ‘nice girls cannot have sexual desire outside of love’, and cites Dierdrie Wilson to the effect that the existence of a love attachment prior to sex is a ‘fundamental rule governing young women’s sexual behaviour as it offers protection from a reputation of sluttishness’ (Lee, 1986:50-1).”

Thus not withstanding the overweening emphasis on cognition and measurable facts in health services research on teenage pregnancy, there should be recognition that Psycho-social aspects like emotions might be relevant in given circumstances.

However, whereas this may be the case with ‘most’ adolescents ‘elsewhere’ especially in developing countries, contraceptive use among adolescents in the Netherlands has further improved over the years. Rademakers (NISSO 1999:3) reports that at the present, 85% of the Dutch teenagers use contraceptives at the first intercourse: 46% relied on condoms, only, 13% on the pill, and 24% on the pill and condoms, also known as ‘double Dutch’. This implicitly suggests that there might be something unique about the adolescent reproductive situation in the Netherlands. It could have a lot to do with the socialization

Most of the arguments made in articles edited by James and Gabe (1996) cited above are based on fieldwork carried out among youth in the Ireland. For some of them the authors do not clearly indicated where the fieldwork was done.
process, defined as the ongoing process of social interaction where individuals right from childhood are both consciously and unconsciously induced by key actors in their social environment to learn values, acquire skills, make choices, seek new roles and conform or alter existing behaviours.

The current study has attempted to identify socio-cultural and service factors that could be influencing the reproductive health situation in the Netherlands. The focus has been on factors influencing low level of teenage pregnancy in the Netherlands.

2.2 Historical Perspective of Contraception and Adolescents Reproductive Health in the Netherlands

Until recently, debates on reproduction in the Netherlands were mainly focused on fertility control. In contrast with other European countries (such as France), the Dutch birth rate did not decline during the 19th century (Hardon and Sciortino 1994:11). During this period, it was noted that couples from the lower classes bore more children on average than couples from the upper classes. It is contended by Rollings (1987, in Hardon and Sciortino 1994:11) that in order to prevent a mass of poor people from plunging society into chaos, it was determined that population growth had to be controlled.

However, there was no reliable contraceptive method until 1880 when the diaphragm was invented. The diaphragm, and more generally the idea of contraception was by then hardly acceptable to the population at large (Rollings 1987). Further more, the dominant view on sexuality had to change such that sexuality separated from reproduction could no longer be considered immoral. The link between contraception and population control only gradually disappeared. It is premised that this probably occurred due to the decline in population growth which the Netherlands began to experience at the beginning of the 20th century (Hardon and Sciortino 1994:11). These authors further argue that the introduction of the pill during the early 1960s added new fuel to the debate concerning fertility control in relation to sexuality.

The fact that unmarried women (including adolescents) increasingly had access to the pill led to the questioning of women’s traditional role. This led to clashes between feminist groups and other ‘conservative’ social groups. Women who used the pill were considered immoral as “women who wanted to be readily available to men”. Some religious groups especially the Catholics, one of the largest religious denominations in the Netherlands found it difficult to conceptualize sexuality outside of marriage, and sex not leading to procreation.

In 1980, Evert Ketting referred to the Netherlands as the country that is closest to exemplifying the “perfect contraceptive population” (studies in Family Planning 1980:12: 385-394). Yet 20 years earlier, contraception was not readily available in the Netherlands and family planning was not openly discussed. Displaying and selling contraceptives were restricted and the medical community accepted no role in family planning. However, in one decade, five major factors created a paradigm shift to what is known as the Dutch

- The Netherlands moved from a predominantly agricultural society to an industrial society;
- Rapid population growth led to the development of a welfare state with an extended social security and health care system;
- The influence of religious institutions on personal decisions and shaping public policy declined;
- Educational levels increased in the entire population;
- Mass media particularly television was introduced on a large scale.

These influences supported a shift towards tolerance of consensual and responsible sexual expression. Since then, the Dutch have systematically reduced structural and interpersonal barriers to the practice of safe sex for all sexually active persons.

In 1969, the Netherlands legalized selling contraceptives and providing condoms in vending machines. By 1971, the National Health Insurance included coverage of the pill. In 1981, the Netherlands legalized abortion although high levels of contraceptive use began to drive abortion rates lower than in the surrounding countries. In the 1980s, the Dutch government funded the Rutgers Foundation to provide special services for the adolescents and reproductive care to the public and to provide sexuality education.

In a similar note, Hereen (1978), cited by Hardon and Sciortino (1994) noted that contraception and the pill especially, became widely accepted among all social strata in the Netherlands and religion no longer accounted for differences in pill usage. As Rademakers (1996:341) aptly noted, in the Netherlands, a general attitude of openness and tolerance towards sexuality evolved during 1965-1975, partly because of the increasing recognition of the public health effects of unwanted pregnancies, especially among adolescents. Prevention of unwanted pregnancy came to be defined as a public duty, not just a personal concern.

This submission suggests that most of the Dutch have developed a tolerant and above all, pragmatic attitude towards contraceptives in general and towards abortion as an emergency solution. Modern contraceptives (but not condoms) were provided free of charge by the National health service. Recent efforts to impose a charge were so fiercely resisted that the government withdrew its proposals (David and Rademakers 1996:341). It is stipulated that, the Dutch propagate contraception as a means to prevent unwanted pregnancy and the “abortion bomb”, whereas in the south contraception is seen as an instrument to avoid the “population bomb” (Hardon and Sciortino 1994:13). This is largely attributed to fact contraception is no longer relevant as an instrument for population control because the Netherlands are characterized by a near zero population growth. Hardon and Sciortino (1994:13-14) argue that the policy regarding contraception is based on the government’s policy to respect the right of every couple to decide freely and responsibly on the number and spacing of children.
The policy’s focus on responsible decision implies that couples have to be well informed about sexuality and the pros and cons of each contraceptive method available. To be able to realize this objective, it is asserted that contraceptive services are organized to provide both contraceptive methods and information on contraception. It is stated that all contraceptives can only be obtained after a medical prescription with the exception of the condoms (Delft & Ketting 1993).

The key figure in the Dutch system’s provision of the selected contraceptive methods is the physician. The family physician is responsible for the examination of clients and prescription of contraceptive methods. According to Delft and Ketting (1992), the family physicians play a central role and are partly responsible for the pills wide popularity. They regard the pill as the most reliable contraceptive method. Women’s Health Centres are also hailed by some authors for their role in informing women and offering assistance to them regarding their needs and problems related to sexuality and reproduction. In addition, offices of the Rutgers’ Foundation are involved in the provision of contraceptives, although this is done on a smaller scale. According to Hardon and Sciotrino (1994:17), the Rutgers Association services though not entirely free of charge, remain a preferred alternative for people preferring more anonymity, especially adolescents and migrant women.

They however, assert that the Rutgers Association’s most important contribution lies in the provision of information on sexuality, reproduction and contraception to specific target groups, especially adolescents. The selection of adolescents and immigrants as target groups is not arbitrary but rather closely related to the main aim of contraceptive services i.e. prevention of unwanted pregnancy, and in turn, abortion.

Rademaker (1990) reported that statistically, adolescents and migrants are the main risk groups for teenage pregnancies. She noted that in 1988, 43% of the teenage pregnancies in the Netherlands resulted in abortion. This percentage has sharply declined over the years. Rademaker (1990) claimed that ineffective contraception behaviour is primarily the result of lack of control regarding sexual interaction of the risk groups like adolescents (especially the immigrants). She aptly states that; “when looking at teenagers mothers in the Netherlands, we see an over representation of immigrant women”. She however, does not clearly explain why some girls have more control over their sexual interaction than others.

As can be noted from the foregoing literature review, most of the literature gives a description of contraception and reproductive health in general but gives very limited attention to the area of adolescent reproductive health, especially the factors influencing teenage pregnancy. In most of the studies, teenage pregnancy is not problematized but is rather fragmentary dealt with as one of the many research issues. It is studied as an addendum but not a core of the research projects. This study has therefore been one of the attempts to focus on the factors that are influencing the low level of teenage pregnancy in the Netherlands.
Statement of the Problem

The Netherlands has the lowest teenage pregnancy and abortion rates both in Europe and the world at large (Ketting and Visser 1994, Rademakers 1995, 1996 and 1999:3, Berne and Huberman 1999:ix). The improvement of contraceptive use in the adolescent age group has led to a further diminishing of teenage birth rates in the Netherlands. For example, the 1992 teenage pregnancy rate was 9.2 per 1000 women aged 15-19, whereas the U.S. rate for the same year was 95.9 per 1000 (Spitz et al. 1996). Thus in contemporary Netherlands, teenage pregnancy is no longer considered a major social problem (Rademakers 1999:4).

A comparison of Sub-Saharan African countries like Uganda which has a teenage pregnancy rate of 43% (highest rate in Sub-Saharan Africa) with the Netherlands adolescent reproductive situation above shows a very wide variation in the magnitude of the problem experienced by these countries and Netherlands. This could be attributed to a number of factors which need a systematic examination. Most studies assume and contend that the youth and women in the North have control of their own reproduction and have access to high quality reproductive services. However, it is rarely questioned whether this ideal image corresponds to reality (Scortino and Hardon 1994). Researchers tend to overlook the relativity of adolescent control over reproduction even within the Northern countries. Some studies which have attempted to look at the reproductive health policy of Netherlands have not explicitly elucidated the role of socio-cultural factors in its development.

The other questions which are yet to be adequately handled are:

- What factors make adolescents in the Netherlands to have better control of their sexual and reproduction behaviour in comparison to their counterparts in the developing world? What is the secret?
- What are the socio-cultural aspects inherent in the socialization of adolescents in the Netherlands that could be contributing to the desirable (low) level of teenage pregnancy?
- What type of advice do adolescents in the Netherlands get (by whom, when, at what age, by what means and in what atmosphere is it communicated and why?)

These questions are imperative and timely because most studies done have given more emphasis to the quality and management of reproductive health services in the Netherlands vis-à-vis low teenage pregnancy. They have largely ignored, if not overlooked the role of the socio-cultural factors in influencing the teenage pregnancy level in the Netherlands. In addition, studies done largely concentrate on the formal channels (media, instructional materials and GPs) through which information is given about contraception and prevention of STDs, they apparently give little attention to the contraceptive knowledge obtained through informal channels in course of the adolescents’ social life. Therefore the study has focused on service as well as socio-
cultural factors that could be influencing the low incidence of teenage pregnancies in the Netherlands.

The theoretical Underpinnings of socialization

Under this heading, the research attempts to elucidate the theoretical realms of socialization. A systematic study of how the individual becomes a participant in his society is of comparatively recent origin. In the 1950s, Child (1954: 657, cited by Varkevisser 1973:12) remarked ruefully; “there is not yet a hard core of well established and interrelated principles around which the study of socialization is focused”. Another scholar Goslin (1969:21) employs a metaphor containing masked optimism: “As a focus of scientific inquiry, socialization is still in its infancy”. However, some disciplines have developed some body of theory about the phenomenon of socialization.

Psychology for example, concerns itself first and foremost with the consequences of the process of socialization for an individual. Child (1954:655 cited by Varkevisser 1973) defines socialization as “the whole process by which an individual, born with behavioural potentialities of an enormously wide range, is led to develop actual behaviour which is confined within a much narrower range- the range of what is customary and acceptable for him according to his group.

Sociologists rather emphasize how socialization functions to the guarantee the survival and continuity of a community: “the process by which individuals acquire knowledge, skills and dispositions that enable them to participate as more or less effective members of groups and the society” (Brim in Goslin 1969:2 and Varkevisser 1973:13).

From the above propositions, it can be expatiated that psychologists focus on the individuals as responding to, rather than initiating interaction and concomitant learning experiences. Sociologists elucidate the learner as consciously making choices, seeking out new roles and deciding as well as being unconsciously induced to acquire new skills or alter existing behaviours. Sociologists and social anthropologists make ‘a brave’ departure from psychologists by forcefully stressing that socialization is an ongoing affair which does not cease with the advent of adulthood but continues through the individual’s life cycle (Aberle 1961:387; Clausen 1968:2; Brim 1968:182; Inkeles 1968:93; Goslin 1969:2).

In addition, sociologists have of recent exonerated the relevance of the notion of reciprocity in the socialization process. They attempt to show that as the learner adapts himself to satisfy the demands made upon him, he influences the behaviour of those who make the demands. This strongly suggests that inherent in every interpersonal relationship is an element of negotiation. In this regard, Goslin (1969:8 in Varkevisser 1973:15) maintains that if child rearing practices in a given society are non-authoritarian, children in relationships with parents, peers and teachers speedily demonstrate an awareness of their power to participate in making decisions about reciprocal rights and obligations.
The study of socialization has been a challenge to most anthropologists. However, culture and personality as a branch of anthropology blossomed after the pioneering work of Ruth Benedict, Margaret Mead and Edward Sapir accomplished during the late 1920s (Kluckhohn 1956:491 in Varkevisser 1973).

For the purpose of this study, I have adapted the proposition by sociologists and social anthropologists that socialization is an ongoing process of social interaction where individuals right from childhood and through their life cycle are both consciously and unconsciously induced by key actors in their social environment to learn values, acquire skills, make choices, seek new roles and conform or alter existing behaviours (Aberle 1961:387; Clausen 1968:2; Brim 1968:182; Inkeles 1968:93; Goslin 1969:2).

From a sociological and cultural point of view, sexual maturation has always been part of the individuals process of becoming an adult in society, with rights and responsibilities that are different from those of childhood and puberty. It includes becoming independent and separated from parents, becoming a full member of society, gaining the right to start raising a family, and acquiring the responsibility to care for and maintain a family (Ketting 1996:12). Sexuality has always been looked at as a dangerous and difficult force to control in adolescence.

It is further noted that through its potential consequence of pregnancy and child birth, sexuality could force a person into the role of adulthood, before it would be socially and culturally acceptable, or a wrong partner. Ketting noted that, to prevent these dangers, almost all cultures have developed strategies to exclude the risk of sexuality and pregnancy at an age, or with a partner that would not be acceptable. Basically four types of cultural strategies have been developed in history to exclude or at least minimise these risks: very early marriage, extreme segregation of the sexes in adolescence, internalization of morality of sexual self-restraint, and encouraging positive and responsible sexual behaviour.

The study premised that the western societies especially the Netherlands has made considerable progress in its socialization of adolescents in line with the fourth strategy. It is within this theoretical enclave that the role of socialization agents like parents, peers, the media, the church, the school and reproductive health providers was conceptualized to be affecting the adolescent sexual behaviour and the trend of teenage pregnancy in the Netherlands.
Chapter Two

Objectives And Methodology:

Overall Objective

To identify factors contributing to low levels of teenage pregnancy in the Netherlands.

Specific Objectives

1. To examine the role of the relevant socialisation agents (parents, the media, peers, schools, health workers and the church) in the Netherlands play in influencing the level of teenage pregnancy;

2. To establish what, how, when and from whom adolescents learn about sex and sexual relationships;

3. To unravel the dynamics of communication between peers, parents and adolescents, and service providers and adolescents with regard to sexuality, pregnancy and contraception;

4. To explore the perceptions of adolescents towards sexual relationships, use of contraceptives and teenage pregnancy and;

Methodology

Research Type and Design

To generate the required data, the study has largely employed qualitative methods of data collection. The study generally embraced the exploratory research design with description and comparison as a strategy. The study has used both primary and secondary data, collecting these from purposively sampled sources. Ethnographic data reflecting the experiences, views, perceptions and attitudes of the relevant informants will be gathered.

Study Population

The study population was largely composed of adolescents ranging from 15 to 20 years of age. All in all the study covered 14 adolescents; 8 girls and 6 boys. Five parents; four mothers and one father were interviewed. They proved to be a useful resource for the study. Key informants of varying research and practical experience about the subject of study were also interviewed. They comprised two research fellows and two program managers of adolescent reproductive health programs (Rutgers Stitching). In addition,
four focus group discussions were conducted. Two for girls, one for boys and the other a mixture of both girls and boys.

Selection of Study Participants

The main study area was the city of Amsterdam. Adolescents (aged 15-20 years) formed the largest proportion of the study participants. They were purposively selected. Majority of them were students from secondary schools and universities in Amsterdam while others were selected in the neighborhood of Amsterdam like Zandam and Maarsen. The researcher had planned to choose schools from different locations of the city as entry points to facilitate diversity and comparison of opinions of adolescents from the different geographical locations of the city. However, this was not possible because most students were on holiday and it was going to take quite a long time to get permission from the various school authorities to conduct the research. Faced with such a dilemma, the research decided to largely apply the snowball sampling technique. This enabled him to informally secure informants through their friends, mothers, neighbours and school mates. Some lecturers were also useful in introducing me to some of their friends who had children in this age group. In addition, the researcher was able to secure and use the e-mail list of both the academic and support staff of the Faculty of Social Sciences. This did not directly generate many study participants but those to whom e-mail messages were sent introduced the researcher to some adolescents and parents who happened to fall under the category of respondents relevant for the study. Key informants were chosen not on the basis of location, but on the basis of their knowledge and experience with regard to the issues problematized in the study. The researcher was also be flexible in the selection of parents. Parents from within and outside Amsterdam were interviewed.

Data Collection

Secondary data was collected for purposes of comparing the present study and other studies carried out on related fields. It also helped to supplement on data collected from primary sources. The abstraction of needed data from documents was guided by a check list of the issues on which information was sought.

Primary data was collected by use of in-depth unstructured interviews and focus group discussions (FGDs) covering a wide range of informants. Focus group discussions and in-depth interviews were guided by a list of themes or issues that will be considered pertinent to the study question. Focus group discussions basically covered adolescents. The researcher conducted two FGDs for adolescent girls and one for adolescent boys only and one where boys and girls were together. Through the FGDs, informants were often motivated to challenge and positively criticize each others’ views and perceptions.

In-depth interviews were conducted with different key informants that the research was able to identify and interview within the limited time and resources. They comprised two research fellows and two program managers of adolescent reproductive health programs (Rutgers Stitching).
Five parents; four mothers and one father were interviewed. They proved to be a useful resource for the study.

Another ethnographic method of data collection that was employed in the execution of the study was observation. A checklist of issues to be observed was drawn. Observation of sexual related behaviour of adolescents in trams, tram/bus stations (stops), bars, movie halls, disco halls and condom vending machines was done. Where possible, the researcher also observed interactions between adolescents and reproductive health service providers at the Rutgersstichting clinic in Amsterdam. The researcher also visited two families to observe how parents may react while watching movies on the television which had pornographic scenes. On the whole, though the field work exercise was a daunting task, it was very interesting and revealing for the researcher.

Data Analysis
The completion of the data collection exercise was followed by data ‘cleaning and processing’. The aim was to iron out the inconsistencies elicited during the interviews. Data collected recorded in note form. Micro recorders were used, with the consent of the relevant informants. Transcription of the data from the macro recorders was one of the major and daunting tasks for the researcher. Nevertheless, it had to be done. Qualitative data generated through FGDs and informant interviews were analyzed qualitatively. A thematic procedure was used where participants in FGDs were assigned codes. The major issues of concern related to the itemized subjects and the corresponding answer categories were classified by item of a particular theme.

Content analysis was carried out whereby field notes were categorized according to the research themes. For purposes of validity and representation of the emic voice from the field, specific informants’ profiles or narratives have also been cited.
Socialization Agents: Their Role in Shaping Sexual and Contraceptive behaviour of Adolescents in the Netherlands

One of the specific objectives of the study was to establish and describe the contribution of the relevant socialization agents in promoting low levels of teenage pregnancies in the Netherlands. The major socialization agents that were identified during the study were:
(a) The parents;
(b) peers;
(c) The media;
(d) The school;
(e) The church;
(f) Service providers (GPs and Rutgers consulting workers).

Parents-Adolescent Interactions and their Contribution to the low levels of teenage pregnancy in the Netherlands.

For the purpose of this study, parents were conceptualized to refer to mothers or fathers and guardians. All study participants acknowledged the role of parents in shaping the sexual behaviour of their children. However, the dynamics of extent to which parents contributed towards the sex education of their children and the impact of that sex education on the sexual and contraceptive behaviour of the adolescents was a complex one.

There were notable differences in the levels of openness and willingness of parents to talk to their adolescent children about issues related to sexuality and contraception. Nonetheless, the outstanding opinion raised by most adolescents and the parents was that parents were more comfortable to answer questions about sex asked by their children but that the children are less comfortable to pose sexually intimate questions to the parents. Most of the adolescents seemed to suggest that the parents are to a good extent willing to be asked questions about sex but the adolescents feel that these issues are so intimate to discuss with the parents. Some parents also said that they are willing to discuss questions about sex but their children are shy and rather uncomfortable to talk about their intimate lives with the parents.

In this case, one could argue that an indirect form of socialization, that of imitating behaviour could be the one at work. For instance, if the mother takes pills then it is probable that the daughter may be stimulated to ask a question about the pills and/or take them too.

However, this cannot be generalized to all interactions between parents and children. It was found to be relative from one family to another. In addition, it also depended on the type of questions and topics of discussion. Adolescents may feel more comfortable to
discuss less intimate topics, especially those about contraceptive pills and condoms in general than specific topics about what they are doing in their relationships. Thus it might be easier to talk about the tools to ensure safe sexual practices than to go to specific details of what and how of a relationship.

On the whole, adolescents and parents reported that in their interactions, the latter are willing and open when approached on any question about sex. This is a major breakthrough on the part of the parents that can not be underestimated because it is the a vital step in helping to facilitate communication between adolescents and their parents about sensitive topics like sex. It gives a message to the adolescents that whenever they want to talk or ask something about sex, the parents will be there for them and will be glad to listen to their questions. If adolescents are aware that their parents are willing to answer any sexual paradoxes, and parents feel that it is there role to help their children learn to make responsible decisions about sexuality, this could create a strong motivation among adolescents to discuss such issues with their parents. However, there are some adolescents and parents who felt that it was still a bit of a taboo to communicate about sex. It would be wrong to assume that people in the Netherlands are very free when it comes to communicating about sex. But some of them would sometimes confess that if asked questions about sex they would not hesitate to answer. They tended to suggest that the communication was restricted to posing questions. This further shows the relativity of opinions about openness in interactions between parents and children.

To verify these assertions documented above, some quotations in form of narratives by study participants have been shown below. They indicate the relativity of communication between parents and adolescents about sexuality.

For example, one of the study participants; a boy, 19 years old, a first year University student was asked:

Interviewer: Did you ever ask your parents any questions related to sex?

“Oh! no. I think I would feel uncomfortable to ask my parents about sex. In this case it was like a taboo for me. I really never had the feeling to ask my parents. Mum and Dad always said that I should try to use a condom...But in case of big problems like pregnancy I would tell my parents. But I would tell them like.. I would be very afraid what they would say”.

In a similar note, an 18 years old girl studying in high school lambasted her parents when they tried to discuss with her matters about sex:

“Mother and stepfather said something like you can get pregnant when you go with a guy in bed and how it happens when you fall in love. I said come-on! you come with it now. Are you crazy?. I wasn’t interested in the story because it was nothing new. If I wanted to do something I would have done if long before. I feel that parents want to control their children, they want to know what you are doing. That is nice as far as it is not about

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things like sex or safe sex. Because safe sex is my business. You do not have to know what I am doing. If they started to discuss it with me when I was twelve, I would have been interested because it was new but now ahaa no”.

From her submission, it can also be noted that her parents started to discuss issues regarding sexuality with her when it was quite late.

In the same vein, Roos, an 18-year old high school student in the fourth year made the following critical remark about how the notion of openness in discussing sexuality and contraception between parents and the children has been superficially perceived:

“I think every child in Holland knows that you can ask your parent everything; that is very important how you get your information. Your parents will tell you everything you want to know, but you have to ask first. It has to be out of your own initiative. This is what I see around with my friends and my family. From what I have experienced, the Dutch people are not blunt about sexual matters, but when you ask them to be frank, they tell. Only provoke them by asking a little question about it, they tell you everything”.

She also lamented the ambivalent attitude that exists in her family as well as her social environment with regard to talking about sexual matters openly. She elucidated the moral and normative dynamics associated with it:

“Your mother will send you to the house doctor if you need something, but it is mostly between the lines. But most people think that in Holland it is all open; you can talk about everything. But I think that that is not true. Sex is still a taboo in Holland. People think they are open about sexual issues but they aren’t really. Because when they talk about it, it isn’t in an open situation. Some people are really trying to be more open about it. But still it is difficult to break the wall. The taboo is the wall. Taboo is so integrated in culture, it is everywhere. If you still want to put it in the open, I have a feeling that there is a long way to go and maybe it may never be in the open”.

I went on to probe by asking her, can you give an example of what you meant by telling between the lines? This is what she said:

“Contraceptives, they are never called directly by their name. They are called other things. So as for the pill, it will not be called by its name, ever time a different name. It may be called hormone stimulator. The condom isn’t usually called a condom, it is called ‘that’, it depends on the situation. When it is the appropriate situation and you say, get ‘that’, they will know what you mean”.

In addition, she aptly made an observation which implied that the developing norm is to be open and discuss freely all issues including sexuality but there are still forces of ‘inertia’ that are remnants of internalized taboos regarding free communication about sex. She contends that when people say they are open it is just ‘theater’, ‘impression management’ but deep in their ‘bone marrow’ moral rigidities exist that stand in the way
of genuine openness about sexuality. To this regard, she is quoted to have made the following submission:

"I think in Holland there is an ambivalent attitude. For instance, there is a show called sex booth, it is a television program where people can realize their sexual fantasies. A lot of people watch it, but nobody admits that they watch it. If you ask, 'have you seen the program', they will say 'no, I haven't'. But they have. It is popular but because of the taboo syndrome, people do not admit that they watch it. It can be put in an expression: not done because it is called dirty. People are obsessed with the notion that we should be open and they say they are open but they are not really there. The norm is to be open but in reality they are not yet".

In support of this statement, one of the key informants, a researcher fellow in adolescent reproductive health issues commented on the difficulty for parents to talk to their children.

"Yea, indeed the talk is very theoretical. They would say, be very careful. But words like sex, intercourse et cetera, are not very commonly used. It is not strange that you have sex but it is something adolescents consider odd to talk about especially with your mother. Most girls say that it is not something to discuss with your mother or even friends, it is very private".

Similarly, in an in-depth interview with parents who have a 20-year old son and a 16-year old daughter, revealed that adolescents could be very protective and less open to their parents about sex-related issues.

Interviewer: Do your children ask questions about issues to do with sexuality?
Mother: “They are quite restricted in asking sometimes. They are not very open and they never ask questions. Our children are quite closed, they are not very comfortable in talking to us about their intimate things. They are scared that their privacy will be broken by us. So I am a bit in the background. I do not try to force them. If they do not want to talk about it, then I am not going to insist”.  
Father: “ they are less open on these matters (sex) than we are”.

In line with the above argument, a mother of two adolescents (a boy and a girl) made the following remark:

"It depends on where you live in the Netherlands, and how the relationship is, and your own background in this case. When you walk through Amsterdam, you think that Dutch people are so free and they talk about their sexuality, their sex life and that sort of thing. But I am not sure if that is the case. They give this information but this information is business like. I do not think that they talk a lot about it with their children but some parents especially mothers advise their daughters to go the GP and ask for the contraception pill. It is more biology than about experience and what to do when you are in a situation and you love each other very much and then take precautions in that
Situation. So the taboo about sex in the Netherlands is bigger than what is assumed. The other scenario is that children between this age are often very reluctant to take advice from their parents. It is a kind of natural resistance within our culture. You have to resist your parents and look for yourself and all the things in life”.

In conformity with this opinion, one of the girls in a focus group discussion, 17 years, a student at a hair dressing and make-up artist school said:

“I don’t dare to, nor do I intend to discuss with my parents anything about sex. To me parents are the last resort to communicate to issues about sex. I have learned most of the things through my personal experience and from my friends. To me friends are the best teachers”.

Similarly, in a focus group discussion with two boys and two girls, it was generally agreed that parents are more open and willing to talk to their children about sex than the children. In this FGD, a girl of 16 years old, made this remark:

“I never ask about that kind of stuff to my parents. I go to my brother or my friends. But it isn’t because they can’t talk about it but it is personal and they do not need to know it”.

In the same FGD, one of the boys aged 20 years made the following observation:

Sometimes my parents say little things about it, well if you want to know anything you can ask me, but I never wanted to ask them because I found it personal. Then maybe it is more of a taboo for me to talk about it than for them”.

From the foregoing opinions, it could be deduced that what probably makes the parents’ talk theoretical is the culture of resistance and protectiveness which adolescents display to their parents. Parents are not given the opportunity by the adolescents to discuss sexual issues. This may de-motivate some of the parents from openly discussing sex related topics with their children. It could be that some adolescents lack the motivation and skills to tell their parents about the challenges and unanswered questions they have on sexual issues.

It could also be that despite the fact that parents could be willing to answer questions from their children they are yet to develop skills and ‘teen-friendly’ approaches to motivate their adolescent children to ask them questions about sex. It could be that children think their parents have prejudices about the way adolescents lead their sexual lives. The pertinent issue then becomes, how to create an enabling environment that would reduce the tension and enhance communication between parents and adolescents about sexual matters.

Notwithstanding the above opinions, other study participants had another story to tell about these issues. They applauded the role of parents in enhancing safe sex and low levels of teenage pregnancies in the Netherlands. They aptly articulated that parents are
free to talk to their children about sex and that adolescents feel free and comfortable to talk with their parents about the subject of sex and contraception.

For example, in an in-depth interview with a boy of 19 years, a high school student, he said:

"My father is most of the time not home. But my mother tells me what girls like and what to do with them. What makes them comfortable. If I have any question I go to my mother and she would always be glad to answer them. For instance I asked what I had to do to make a girl comfortable. She said just put on nice music, what she likes and take it slowly, do not rush things. I did that and I succeeded, it was good".

Another adolescent, a girl aged 20 years, a first year university student, made this observation:

"I lived with my Dad, I feel free to ask him questions. In our house it is not a big deal. We feel relaxed when we have some questions to ask. It is not like they tell how they do it, like Dad and his girlfriend, neither do I want to know what they do, but it is more like sometimes he said that once you have got some questions do not hesitate to ask me. It was more like if I had some questions it was okay to ask but this rarely happens".

In addition, a girl, 20 years gave the following synopsis of her experience with her parents regarding sexual issues:

"I think sexuality has never been a big issue in my house. We have been talking over it very openly and I had never thought of it as something strange; something I would keep a secret from my mother. When I had a boyfriend, we talked about birth control very openly with my parents. It has been a very positive idea to talk about. I was 15 years old when had my first serious relationship and my mother came over to me. She gave me some condoms to use and we chatted about it. I haven’t got such a good contact with my father they split up at that time, so my father is kind of out of the picture in this whole experience. Though with my grand parents, I have very open conversations with them too and we discuss my social life with my grandfather. For instance, I can talk with him about sex very easily".

Further more, in a focus group discussion with boys aged 16-20 years, they made the following observations about parents and about sex education and contraceptive behaviour:

"When you are 15 or 16, they talk about it with you. They emphasized that when you do it, do it safe. Your parents know your life. They think when you are ready, you should have sex but have it safe. So they give you condoms. When I am going on vacation they give me condoms. Apart from giving you condoms, they explain to you not to use her but to love her. They tell you to respect her; not to get a girl and dump her there. Some parents talk about their first time but this is when you are lucky."
Further still, when one of the parents was asked about the extent to which she gives her children sex education, she gave the following response:

"I have virtually told her everything. I have three children, my daughter is 18, my son is 21 and the other son is 12 years old. When they ask me about sex I tell them information but I adjust it to their age. When my daughter had her first boyfriend, she was 14. She was very young, which gave me a lot of sorrow. From that time on I told her that if she is going to have sex with someone, she should use contraception. We believe that people take their own responsibility no matter how young they are. You say to the young child that you sleep with him, but it is your own responsibility to look after not getting pregnant. Our role is to make the children aware of the dangers and possibilities".

This suggests that most of the parents could be putting more emphasis on promoting safe sex behaviour in their communication with children about sexuality.

In a similar vein, another mother of a daughter of 18 years elucidated her own experience with her daughter:

"My own experience is that I never said to my daughter, well don't or do. I also never told my daughter to go for the contraceptive pill. She did it herself. We always talk freely about sex and what it means to have sexual feelings and how you can express yourself when in love. I didn't have to warn her not to get pregnant because from our conversations she knew what the consequences would be of having sex with a boy, namely that you could become pregnant. She decided not to become pregnant at a young age. As a kind of joke with her boyfriend, they talk about babies and then I say don't you dare because I do not want to be a grand mother who takes care of the small child all the time. When she forgets to take her pill she comes to me and says, oh! mum, I forgot my pill, won't I become pregnant? I think this is a sign that we are very open".

Another parent (mother) of three adolescents: a boy of 20 years, an 18-year old daughter and a 12-year old boy gave a similar response to this topic:

"My daughter and I are sort of friends. We talk about everything and also about this subject. For example, when my daughter's period is quite late then I say, 'You are pregnant, aren't you?' I always tell her that if it happens, she should tell me. She should not be afraid. I may feel terrible but if it happens, I would help her out. It is very good to be open not only about sex but also on all subjects when they are young because you get fruits of it when they are grown up. They can be more of friends than children. When they are older and not in this house anymore, they come to me just because they like to see me and not because they have to see me. I want my children to perceive me not as an authoritative figure but more of a friend and/or partner".
Similarly, during my interview with a key informant from NISSO, she aptly observed that:

"We are very communicative with our children. We are not very authoritarian. In general we take them seriously. We teach them to come up strongly and to be in control. This helps them to gain confidence in taking their own choices. The freedom we give them is however, backed up with a lot of information to enable them take responsible decisions".

These observations tend to suggest that there is relatively good communication about sexuality and safe sex behaviours between parents and children. Some parents-adolescent interactions are very open and they can discuss both the methods of contraception and other positive values of sexuality. Some are "moderately" open, that is they talk about protected sex, while others "least" communicative which means that they rarely share ideas and information about sexual topics with children.

Communicative parents and adolescents may have broken the wall of taboos and moral rigidities that have prevented other parents and children from openly discussing sexual matters. It could be that these parents have created an environment of mutual trust, thus making their children more comfortable in talking about their sexual feelings.

It is also observed that most parent-adolescent interactions focus more on promoting positive sexual attitudes and behaviours rather than discussing intimate details about sexual relationships. There also seems to be emphasis on responsible sexual behaviour. Such purposeful communication may have a fundamental contribution to improve the coping mechanisms of adolescents towards challenges in their sexual lives. It may thus be one of the vital factors contributing to low levels of teenage pregnancies in the Netherlands.

The non-communicative parents and adolescents may still be struggling to break the wall of taboos and other social barriers that make communication about sex difficult. They still need better skills and motivation to enable them overcome the social inertia that may negatively affect their interactions. It is possible that the adolescents affected by such a comparatively less communicative family environment rely quite heavily on other socializing agents like peers, the school and the media which are yet to be discussed.

For example, Rademarkers in her Ph.D. study of adolescent reproductive behaviour reported that only few adolescents (7.9%) let their decision to be sexually active depend on parental approval, the major reason was need for a longer courtship (70%). This presupposes that open communication between parents and adolescents is not for purposes of getting parental approvals and imposing control of adolescents. Rather it may help them to benefit from vast knowledge and experiences about sexuality which their parents may share with them. This may ultimately make adolescents cope better with the "episodic sexual shocks" of this human development phase. Thus this combination of a highly liberal and open attitude toward sexuality and preventive information (Evert
Ketting-NISSO, 1996: 16) inherent in the culture interaction between parents and their adolescent children may be largely responsible for the low teenage pregnancy rate in the Netherlands.

Spontaneity of sex education by parents

The findings of the study suggest that sex education by parents occurs more in a spontaneous than in structured pattern. It happens naturally like in any other family activity. It may start from a normal conversation, a joke and or a television or radio program. Depending on the nature of the message, it may be given when the whole family is there at a meal or if it is specific and intimate to a certain child, then it will be given to him or her privately. Where both parents are still together, it may be given by both mother and father.

The boys tend to suggest that they go to the parent whom they find easier to discuss about intimate sexual issues. They felt that both parents are responsible for them. Girls were mostly given education by the mothers but in some cases fathers could intervene. Below are some of the issues that the study participants were quoted articulating.

A mother of three adolescents made the following remark about how sex education happens in her home:

"I do not tell my children that; sit down, it is now time to talk about sex. It just comes up like anything else. It is not a special thing. It may even start from a joke and ends up into a discussion about sex. It is not like I am saying one evening, come and sit with me and I will tell you everything. It happens spontaneously, when they are curious and they want to know I tell them. My husband and I sometimes answered questions together. My son one time asked, how do babies get in your body, they come out but how do they get there. Now that my children are grown up and almost know everything. It is comfortable, easy to communicate with them about sex."

In an FGD with boys (16-18 years old) at a vocational school in Amsterdam, the participants made the following observations:

"I think it is easier with mothers and daughters. Both parents are responsible for you and they have both sexual experiences. So, the task is not divided according to their sex. It doesn't matter, it can be either of the parents talking to you. If your relationship is easier with your father, then you are going to talk to him and not your mother.

However, there is one case where a boy of 19 years noted that his father is less comfortable to discuss sexual issues with. He felt that his father gives unnecessarily short answers but the reverse is true with her mother. In the interview he said:

"I do not ask my father much, but when I ask my mother something she explains a lot she tells stories about it and my dad just says what I want to know and it is over. My dad
takPs
less than jive minutes. I think that my dad is less comfortable to talk to me about sexual subjects than my mother”.

This suggests that there is no division of labour or tasks according to the gender of the children and the parents. Both parents were perceived to be equally responsible for sex education of children. The major issue to the adolescents in this group was convenience, in terms of with whom they feel comfortable to communicate about their sexual life. The other motivation may be the adolescent’s perception about which parent has more knowledge and experience about the kind of issue that the adolescent would like to know more about.

In a similar note, a 20-year old girl in high school was quoted to have made this observation:

“I didn’t have one specific big talk when my mother sat me down and said now it is time to talk about it. It wasn’t that all was said at one moment. I was 15 years of age when I became sexually active and I knew what was going to happen, I was ready for it. My mother and I talked about it several times. Which was your first kiss and my mother knew what was going on about me. Actually she did tell me precisely what to do with the condoms”.

In addition, a mother with two teenage children described the manner in which they discuss sex at home:

“Well, it goes up and down, it depends on what you experience in a certain period. When my children are very young, they had questions and we answered them and when there are problems we discuss them. But I mean the problems of my daughter and son not my sexual problems. Although we tell them what it means to have sex and what we experience in a very general way. If there are problems, say it (sexual intercourse) hurts then my daughter comes, tells me and asks what can be done. So it goes up and down, sometimes it is intense and some times not. It is part of life”.

Furthermore, a mother with a son of 20 years and a daughter of 16 years stipulated that:

“When my son got his first girlfriend, I gave him some condoms. I did it very casually, I didn’t want to worry him. I have a feeling that that is something I shouldn’t have done. It was really not the suitable thing. He didn’t need them I think because as I later came to know, they were just still courting. It is a kind of story or tale in the house;...do you remember when she gave me condoms. It was something laughable. Maybe he thought that it was meddling in his affairs... I feel that I had overstretched my confines”.

During this interview, the father was present too and he said:

“That was a very important thing. When he made a sexual contact, he knew that his parents were concerned about his sexual behaviour”.

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However, this does not only reflect the spontaneous nature with which parents handle issues of sex education but it reflects the strong motivation and determination parents have towards ensuring that their children have protected sex. To this mother, sex was not the issue, she didn't express any prejudices towards it. Her simple message was, it is okay, you can do it but do it safe. This was a message to the boy that his parents are seriously concerned about the couple’s sexual health. This is a good example of the pragmatism that most authors who have written about the Dutch reproductive health issues have exonerated.

The above remarks by study participants give the plausibility that sex education by parents is done very informally and it is given in contingency to the situation at hand. Different situations require different approaches and unique skills of responding to the adolescents’ sex education requirements. Different children require different approaches and messages. Sex education is therefore adjusted to the characteristics of a given child and to the unique situation. This suggests that there is more or less no room for stereotyping and rigid schedules of sex education by parents to their children.

Reaction of Parents Towards Adolescent Sexual relationships

Generally, the respondents described the parents reaction to teenage sexual relationships as positive and more or less non-prejudicial. But in isolated cases, parents were concerned about what they called very young adolescents engaging in sexual relationship. By this they meant adolescents below the age of 15 years.

For example, 20 year old girl said that her father responded positively to her being in a sexual relationship. She said:

“He was very happy for me. He was very curious to see him. It does occur in Holland that some parents find their daughter too young to have a boyfriend like when they are 13 or 14 but even this did not happen to me because I was 17. We did not take it very seriously when I was young. Well they were just happy for me. It was normal for my boyfriend to visit me at my father’s house. And I remember sometime when I had a boyfriend, I told my father that I wanted to have a pill, he said, oh! So you have got a boyfriend. Then we just laughed about it. So he said, I will pay the bill when it comes. That is it. It was just like buying strawberry in the supermarket”.

In addition, a 19-year old male high school student made the following remark about how his parents reacted towards his first sexual relationship:

“Oh! they liked it. But if I did it for the first time, I had to come home with a cake. I actually did come home with a cake and we ate it. My parents said it as a joke. If you do it for the first time, come home with a cake”.

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In this example and many others, the parents took it casually and as a normal happening for their children to have a boyfriend or girlfriend. They gladly welcomed not only the partners but also gave utmost support to the idea of safe sex.

However, there is one case of a girl of 18 years whose mother was ambivalent and rather reluctant to pay the bill for the pills. This respondent may not have been aware that the pills are covered by insurance by that time. She is quoted to have made the remark below:

“Well, I talked about it with my mum but at first she thought or felt that I have to pay for it myself. But when I said that if I have to pay for it my self, it is quite expensive, I do not think that I will take it, then my mother said 'yes, but then things might get out of hand and I want you to be safe'. She said, 'all right I will pay for it'. Then I was happy. But of course if she didn't want to pay then I would have paid for it myself. I am sensible enough. I was just looking up to it”.

In another situation, a mother of three adolescents including an 18 year old daughter told the researcher the following experience with her daughter’s first sexual relationship and how she coped with it:

“It was very difficult. I thought that she was quite young for such an intense relationship. But she obviously had a different opinion. I tried to respect what she wanted. I can say, you can't be alone with him in your room. But then she goes to another room or to the park and that is exactly what I do not want. So I said it is all right but in my heart I hoped it would end. It was my mind over the feeling. My mind said you have to let go, my feeling said she is quite young. Another problem is that I did not like the boy. If it had been another boy, maybe my attitude would have been a little better”.

The same respondent continued her story in which she exonerated her husband’s communication and counseling skills with their adolescent children:

“My husband was better than I whenever we wanted to talk with her about it. Because my emotion got too much in the way, then I was going to say things that I would feel sorry about. I would say you do it. I will go upstairs. We had the same opinion but he would find better words to say it than myself. In Holland, the relationship between mother and daughter is that of more hate and more love. You can be more angry with each other but the feelings are more intense. Maybe it has to do with my mother. I have had many problems with my mother. I could have some traumas from my youth that are affecting my emotions. So when I see this happening I tell my husband to handle the situation. When my daughter got her first boyfriend and my son got his first girlfriend, I told them that you can do any thing you like but you know that there are lots of STDs. So if you do not want to get it, you know what to do”.

The story told by this mother has three dimensions: the young age of her daughter which she felt was too young for intense sexual relationship; her negative attitude towards the
boy as not being good for her daughter; as well as the conflicts she had with her mother in the past. She also felt that her husband is better equipped to handle problems with their children. All these salient factors influenced her reaction towards her daughter's sexual relationship.

However, despite her prejudices about the age and the boyfriend of her daughter, she succeeded in rationalizing the situation in what she called letting her mind to preside over her own will and prejudices. She decided that it is better to let the girl and the boy interact in an environment where she could monitor them rather than scaring them off into a place where she anticipated to have no control at all. This would ultimately rob her of the chances of knowing the course which the relationship was taking. Thus after realising this she allowed her rationality to overrule her subjective feelings. This mother also shows that parents are concerned about their children's sexual health.

This kind of objectification discussed above is in line with Ketting (1996)'s submission in which he argued that:

"If we want youngsters to prevent unwanted pregnancies effectively we should make them feel strong, confident and at ease in doing so. That means we should basically accept the feelings and behaviour of youngsters regarding sexuality. Without that, youngsters will feel confused, embarrassed and guilty about their sexuality and thus will not have sufficient confidence to act in their own interest. After all prevention does mean planning and planning and rational behaviour, and that is difficult to put into practice if mixed and confusing feelings are involved" (Ketting 1996:14).

In the above excerpt, Ketting was implying that keeping control over children's behaviour, that is to say over protection, dis-empowers them rather than enables them to gain control over their own feelings and sexual behaviour. Giving children an opportunity to be in charge of their own situation develops their capacities and behavioural skills to be responsible in their sexual life.

This is what Ketting has called Dutch pragmatism, meaning that the Dutch do not philosophize or moralize at length but instead tend to look for what will work in practice. That is, parents and the community at large, accept the youth as sexual beings and accept sexual intercourse as a logical outcome in intimate relationships. Most adults do not see teenage sex as a problem so long as protection is used. Parents want young people to develop a healthy sexual life. Parents use multiple channels to ensure that teens are well informed and socially skilled. They may also provide teens with condoms and contraception to protect themselves. The main message to their children conveyed directly or otherwise is "you can have sex as long as it's safe; better in our home than on the street". Parents then trust teens to make good choices for themselves and to be responsible.
Chapter Three

Other Socialization Agents

The dynamics of peers as a socializing agent for adolescents and their role in the Prevention of Teenage Pregnancies

One of the socialization agents that was problematized and hypothesized to be playing a role in shaping the sexual behaviour of adolescents was the peers. As noted earlier, some scholars have applauded the role of peers the sexual behaviour of teens. Newcomer, Gilbert and Udry (1980) in Miller (1992:2) developed this argument further by taking a strong stance that while teens may not accurately report the sexual activity of their peers, their perceptions of the sexual behaviour of their friends are highly predictive of their own behaviour. This observation exonerates the social influence of peers upon the sexual behaviour of their counterparts. It premises that the peers are one of the primal agents at the centre stage of sexual socialization of adolescents.

From a similar stance, it has been argued that because schools shape the context in which peer groups develop, the composition of the student body sets the boundaries within which peer groups can form. For example, members of minority groups that collectively exhibit high rates of sexual activity will also be highly sexually active if they attend largely minority schools than integrated schools (Furstenberg, Morgan, Moore, and Peterson, 1987).

From the same perspective, WHO (1994:6) in its school health education manual documented that, even a well informed and skilled person needs to be motivated to initiate and maintain safe sex practices. A realistic perception of student’s own risk and of the benefits of adopting preventive behaviour is closely related to motivation. Peer reinforcement and support for healthy actions is crucial as peer norms are powerful motivations of younger people’s behaviour.

These observations tend to suggest that peers are a safety net during adolescence from which children can not run away from. And since education has become one of the primal objectives of every nation-state, it means that most if not all children will have to get into a certain network of peers. Thus sexual behaviour will in one way or another be influenced by the characteristics and values their peers bring into their process of interaction with each other in the school social environment or otherwise.

However, it would be quite simplistic to think that peer pressure influences all adolescents in a homogeneous pattern. This is because personal traits may also play a role in influencing sexual activity. For example, Card, Peterson and Greeno (in Miller 1992:2) contend that sexual activity is less likely among adolescents who have high educational or career aspirations, who have a greater confidence in their own abilities to affect their environment and who have a lower propensity to take risks. They further
argue that even personal skills come into play, for example, high achievers in school and more assertive teens are less likely to become sexually active.

This gives insight not only in the heterogeneous nature of the adolescents but also the coping mechanisms they employ to cope with the sexual demands placed upon them by their social environments. Depending on the kind of coping resources (skills, aspirations, visions, motivations, values, upbringing, extra), adolescents may react differently to the demands imposed on them by their peers.

Peers as a Socialization agent in the Netherlands

For the purpose of this study, a peer was taken to mean a person who is of the same age range, more or less equal in rank and status or ability. Since the main concern was with adolescents, it concentrated on adolescent peers; both boys and girls aged 15-20 years. Study findings unraveled that communication within peers about sex was primarily about feelings/emotions than about technical information on sex. Most study participants were of the opinion that from friends adolescents get more of emotional support than technical information.

They tended to cogitate that their peers knew more or less what they knew and on technical issues they would be as less informed as they were themselves. For technical questions they mostly addressed them to significant others such as parents and health workers. But some, especially those whose parents were less open about sexual topics found friends useful in educating them about sex related questions. Most adolescents seemed not to agree to the notion of peer pressure, they felt that they can take their own decisions.

For example a girl, 18 years old, high school student made the following remarks:

"I have a few close friends with whom I talk about it. We are telling our own experiences with each other. I think I am not learning from it but it makes your world less small. You see that it can be different than what you have experienced. When you have an experience, you may think it goes like that but you hear other stuff from other people and you say oh! It could be different and before you never think about it".

I probed further by asking her: specifically what kind of experiences do you share?

She said:

"If I tried something new with my boyfriend and I am glad of it, I am gonna tell them. And if they try something new, they also talk about it. I know that one of my friends was too late with her menstruation and she told me. I advised her to take a pregnancy test but she was afraid but after a week she became fine. Aaa! It was a tense moment. With a friend we are gonna talk about everything. If it is a sad story she is gonna cry or I am gonna cry or we are both gonna cry. If it is a happy one we are gonna share the
happiness. For example, my friend, a boy, he had a relationship a year ago. And it doesn’t work out. So he was very sad and crying. He came to me often crying. Asking me what shall I do. He loved her but she did not. What I did was to listen to him and sometimes talk to him. When he was crying I haggled. I told him, that it was sad for him. After two weeks I take him out to make fun and he was laughing again”.

In a similar way, a girl aged 20 years, and studying in a teacher training school observed that:

“I do not think that my friends contributed to my knowledge about sex. The peer group I was involved with was not so quick at boys and sex. I was basically the one who was most involved with boys. Oh! That boy is wonderful, amazing. They did not find it interesting. I think I was the one who was most interested and informed about sexual and love issues. They found it an uncomfortable subject or a little taboo, so I did not think I was informed much from that group. And also because of the openness of my parents, I knew most of the things already”.

In an FGD with two girls and two boys, it was also argued that though the issue of protected sex may come up while communicating with your peers, it is not one of the major pre-occupations. The girls added that they do share their sexual experiences with friends who are boys but the boys observed that they would be very reluctant to do that with girls lest they would be thought of as having masked agendas to table to the girls about sex. In addition, whereas, the boys contended that peers can give incorrect information, the girls expressed more faith in information given by their friends as an embodiment of truth about their feelings, opinions and experiences.

I had the following dialogue with this group about the role of peers in influencing sexual behaviour and giving sex education:

Interviewer: What is your experience with friends as away of getting information about sexual issues?

Bornifance, 20 years, a first year law student:
“ I think the subject comes up when you talk to friends. It is a nice girl or if one slept with a girl and there is something strange about her. Things like that one experiences something and shares about it”.

Anne, a girl 16 years old, high school student:
“They ask how far do you go with the boy and how was it. In joking but not a serious a way, they ask; do you do it safe. Then they say if it is not safe oh! that is not good”.

Bornifance: “I generally speak with my male friends because with my girlfriends we do not speak about sex that much”.

Jennifer: “I share my information with both my male friends and female friends”.

Petier: "I think I would talk to the boys and not the girls".

Bonifance: "I think it is always like a tension between the boys and girls about sex. In general it doesn't mean anything innocent; it is like you mean something with it. At least you have an understanding with a girlfriend when you talk about it but with boys, it is more of a conversation, an exchange, you do not have any second thoughts about it".

Anne: "Maybe my male friends are different from his female friends. But when you talk with boys they can talk seriously and show that they care. But later when you are in a group they can talk about it but for me I don't care. Boys are bragging for other boys. And they want to know the girl who talked to him about it. And so they show off to their friends".

Interviewer: How do you rate information from friends?

Anne: "I think it is correct information"

Petier: "I think there could be some mis-information from friends but the information you get from school is correct".

Bonifance: "But sometimes, you have people who do not do it safe, so they say: "the chance is like 1/1000 that you get a disease" and sometimes it is mis-information because they try to defend themselves. So sometimes I think my friends are telling me wrong information about some stuff, diseases, the way you get aids. But generally everyone has had a good education from school and does know that it is not true. But friends can give you wrong information".

Interviewer: Is there some kind of pressure from friends like to have a boyfriend or a girlfriend?

Anne: "I think that is different depending on, in which kind of group you are. When they are real friends, they don't care whether you have a boyfriend or girlfriend. I think they like it when you have but for you sometimes it is different".

In a FGD with girls (15-20 years) at the hair dressing and make up artist school confirmed some of the information from the other group but also added that after a couple of beers, friends tend to loosen their over protectiveness of intimate information. They said that drinking beer facilitate sharing of intimate sexual experiences with friends which would otherwise be hoarded. One of them who had problems talking to her parents about sex applauded friends as the best teachers when it comes to issues of sex education. Others were a bit reluctant to buy her opinion until she had explained her unique family experiences. For her, it would be an uphill task to ask parents anything about sex.

Jessica 17 years: "We discuss how it is like for you, how was your first time"?
Sarah 18 years: “We share intimate information with friends especially after a couple of beers”.

Ester 20 years: “When you are 12-15 years, it is easy to talk about everything with friends but when you become 18-22, you no longer tell everything to friends. You do not talk much about your intimate life, it would be going too far. It is easier to talk about previous relationships as you age than current relationships”. [All of them agreed to this last statement].

Interviewer: What kind of sexual education messages do you learn from friends?

Nome 16 years: “I had certain words from my peers and then I would go and ask my mum what they mean”.

Jessica: “But mostly we discuss feelings not technical things because we are of the same age. I learnt what a guy likes from a girl”.

Sarah: “From friends, we learn more of how to deal with our feelings and from parents it is more of the technical issues. You do not have to discuss technical things with a friend, you are all young and you do not know anything anyway. Now you already know the technical things so you talk about the feelings”.

Barbara 18 years: “I did not learn anything related to sex from my parents, I had a female friend who knew everything and she told me. I found out for myself other things through my own experience. I take friends to be great teachers”.

Interviewer: Do you think friends can give you false information?

Jessica: “Yea, some things they tell you may be misleading”.

Sarah: “Friends never told me false information because they were talking about their feelings and I think that these were true feelings from within themselves”.

Nome: “Of course friends do not know everything so it is possible that they can tell one wrong information”.

In an in-depth interview with one of the adolescents, a boy of 19 years, it was revealed that from friends adolescents may learn new practical things about sex which they can do later in their sex life. The experiences shared may directly or indirectly shape the future
sexual behaviour of the youth in a given peer group. This young man was quoted to have said:

“When we drink a bit, we talk about it more easily. Some tell about their sexual experiences; How you can get a girl? What one does with his girlfriend? How to get her in bed as quickly as possible? I also once had a girlfriend and I told them what I did with her. From friends, you get to learn new practical things which you can do later. When we are drunk, we sometimes say that; unsafe sex is not for us, we only do sex with condoms but this does not dominate our discussions because it is something quite obvious and between the couple”.

When I probed further by asking the question: With whom do you share information about your relationship? This young man went ahead to narrate me his ordeal:

“We just broke up on Saturday. She wasn’t in love anymore. I feel bad about the breaking up. Because I have feelings for her but she doesn’t have feelings for me”.

I asked him, did you tell any of your friends about this unfortunate incident?

“Yes, but only one of them. I told him about the breaking up issue. He does not understand why she is leaving me. When I have sex, I tell him about it but not as deep as I go in telling my brother. I think it is good for friendly relationship. Friendship is about trust”.

In another in-depth interview involving a 20-year old girl, it was noted that peers give some support in terms of encouraging their friends to have protected sex. In case one of them wants to use contraception and she is reluctant because of fear, they can provide some encouragement to her to fulfill her choices. But she cautioned me that this is not peer pressure because the girl made her decision but was being slow to implement it. This young woman is quoted to have made the following observation when she was asked, What kind of discussions were you having with your peers about sexuality?

“Well as I had a group of friends, I kind of guess we had so. We would discuss that so and so is in love with the other one. But as I remember, one of our friends became sexually active and was sort of reluctant to buy condoms. We thus went with a group of friends to buy it first. We did not know which brand and size to buy. She felt a little bit reluctant to go there alone. So we went there with a group of friends, we made a big night of it and we talked about sex and what we like and not like. Birth control, what we want to use and not to use. But you may mistake this for peer pressure, no. This girl made up her mind and we were there just as friends to escort her to buy it and by chance a discussion on contraception began”.

For her, this was not peer pressure, she felt that peer pressure is a negative concept indicating one’s failure to make own decisions. This may suggest that the influence of peers is not direct in telling them what to or not to do but it may serve as an invisible force that may provide a learning atmosphere through shared experiences. As they relate each others’ stories about new issues and challenges in their sexual lives and how they
have or are planning to practically respond to them, they appraise each other’s knowledge and skills which may enhance their capacities to cope with both current and future sexual challenges.

It could also be that this feeling is influenced by the general norm of autonomy and independence that has developed in most western societies. All adolescents interviewed tended to portray a strong sense of self esteem and the parents also tended to believe that ‘self help is the best help’. This kind of notion may have made adolescents to feel in charge and to either objectively and at times subjectively believe that peer pressure is now a foreign phenomenon in their social sphere of life. In such a social environment peer pressure can then exist only indirectly or covertly. This is the kind of peer influence on social behaviour of adolescents which one can discern while reading through the transcripts above.

This line of argument is quite similar to that made earlier by Newcomer, Gilbert and Udry, 1980 (in Miller 1992:2) about peer pressure. This may not mean direct peer influence but rather a secondary influence which comes from the teens' perception of the sexual behaviour of their friends.

On the whole, friends were exonerated in terms of giving emotional and psychological support to those having sexual relationships. Peers were perceived as a good avenue for sharing and learning new experiences about sex. They were hailed for helping adolescents to expand their sexual horizons. Whereas discussions with peers do not focus on technical issues about sex, particularly safe sex, it is plausible that they were pre-occupied with sharing practical solutions to certain social and emotional problems that are associated with adolescent sexuality. It may be that amidst various sources of technical information about sex and contraception, friends were mainly perceived to be useful as a safety-net for emotional turmoil related problems.
The School as an Agent of Sexual Socialization of Adolescents

Schools are one of the most significant social institutions in that shape many aspects of an individual’s life. The school represents the values, norms, aspirations and the world view of the society. By the age of four years most children may already have started to experience the influence of the school on their social behaviour.

In this case, the school becomes an embodiment of their life experiences for two decades and beyond. Their interaction with peers and teachers at the schools and colleges has a profound impact on their life in totality. This largely influences the social and sexual behaviour of the people especially the adolescents. This is why Furstenberg et al (1987) observed that children in more exclusive schools tend to exhibit similar behaviours are most of their schoolmates compared to those in more heterogeneous environment.

It is premised that schools should go beyond the rhetoric to inculcate development of practical life skills among the youth. It is in this regard that schools have been a target for reproductive health promotion among adolescents. The notion is that you either develop and protect the young people or perish as a nation.
Perceptions of Adolescents of the Sex Education Provided by the Schools

Sex education in schools is premised to be one of the major factors leading to the low levels of teenage pregnancies in the Netherlands.

Study findings unraveled that schools play an important role in empowering adolescents with technical information about sex. This is mostly delivered in the biology lessons by the biology teachers. It was noted that schools do not share a uniform program for sex education. Some schools in addition to biology lessons arrange video shows and talk shows for the students. These are conducted by people from reproductive health organization who deliver adolescent reproductive information to adolescents in schools. This serves to supplement the information given by the teachers.

In both in-depth interviews and FGDs, most study participants observed information given by teachers was business-like and examination-oriented. It was devoid of the practical aspects and challenges which the adolescents face in their social environment. It was mostly about the anatomical structures of the sexual organs and reproductive organs.

At the technical scientific level most schools were applauded for effectively teaching and providing literature about physiological and anatomical dynamics of both the female and male reproductive processes. However the study participants suggest that discussions were geared towards theoretical underpinnings rather than on practical issues that are quite vital in motivating adolescents to initiate and maintain safe sexual practices.

Study participants observed that in some schools sex education begins at the age of 8 or 10 years, while children are still in primary school level. But most adolescents noted that they started getting sex education at the age of 13 years when they are in their first year of high school. Those who got it during primary school years said that they did not get enough information but they got more sex education at the high school in the biology classes.

Some adolescents felt that teachers are shy and uncomfortable while delivering lessons on sex. This affected the quality of their lectures. They however reported that schools and libraries have good information on technical sexual issues such as anatomy, sexually transmitted diseases and how to prevent them.

For instance, Roos, an 18-year high school student made the following assessment of sex education in schools:

"At high school we have biology. There is a whole special chapter on reproductive health. We get to know contraception, the organizations that can help you when you get pregnant. If you do get pregnant you know where to go to get contraceptives. In your biology book at school everything is explained as well. But the only problem is that you get the chapter when you are in the fourth class and most children will be sixteen by then."
Yet some times you know the hormones get to play when they are a little bit young. So there you have a problem.”

The same study participant continued by explaining why she thinks that her school begins late to give sex education and the problem that this poses to them:

“This means then that the parents have to be the source of information. They should begin earlier but then the parents will complain, ’my child is still so young, I do not want to get them that kind of education at that age’. Because parents were complaining, they moved it up to a higher grade. Before the fourth grade, I knew everything, but I just got it between the lines. Also when I was at the lower school I came across a sex education book. Sometimes it is a very little line and a very little line, sometimes when people talk about it you listen”.

She also went a higher level of analysis by observing that knowledge level might be high but it may or may not be reflected in the practices of adolescents. She noted that:

“It is like you learn it for examination so you have to put everything into your head. But another thing is, it is one thing knowing and another thing doing it. So if you know everything it is not complete till you practice it as well. I think adolescents here do put this knowledge into practice because no body I know has ever been pregnant while an adolescent”.

Roos further made the observation that teachers are not comfortable while delivering lectures on sex and their teaching ignores practical aspects of young people like what it means to be in love and the challenges that it brings to an adolescent.

“They find it difficult to talk about it themselves. But they have to do it; it is their job. The strength is they do know everything and if you ask, they will tell you everything but the weakness is they do not talk about it naturally. When they teach the chapter on sex topics, they give quite different than they would otherwise, they are not really themselves. They are a little bit tensed; I have to take this topic today. It isn’t really flowing. Only the instruments but not the experiences and feelings of young people are discussed. But I have had once in a certain school that a teacher performed how to use a condom on a wine bottle. That was very new to me”.

In a FGD with boys aged 15-20 years, the participants compared parents and teachers with due regard to giving sex education to the adolescents.

“The teacher does not talk about his experiences but he talks about global things”.

“The teacher is not ashamed and knows more about the technical things but not feelings”.

“You can ask your parent to explain some of the things you get from the school”.

“The biology class gives more information about sex but not the school in general”.

In addition, an adolescent girl, 20 years old, a first year university student noted that:
I think the home definitely contributes to your ideas and what you feel about sex. At school, it was a kind of funny and everybody knew about it. I have never felt that it really contributed to my situation of sexuality as much as my family did.

This may suggest that teachers and parents work as partners to achieve the goal of giving quality sex education to the children. Each concentrates on the field she can do best. This may lead to synergetic effects where by the strengths of each are maximised while the weaknesses of are minimised.

In the same vein, one of the parents was quoted to have made the following remark:

“yes, they have more information sources, surely that is true. But this more about the technical/biological sides. I do not think that it is necessary to explain to them all that kind of stuff they get at school in detail. In our generation, if you talked about it you would go red in the face but now days a lot of biological facts are taken as casually as those of mathematics.”

“At school in the biology they tell them about what happens when you make love to a boy or girl. All kinds of means for not getting pregnant. But feelings are detached from the message. As far as knowledge and information are concerned they are good-because the children do not want to discuss emotional matters with their teachers too. They do it among each other or with their parents. Depending on the relationship between children and parents”.

The remarks from these two parents suggest that parents believe their children have alternative information sources such as the school where they can get help in terms of technical information about sex. This may be part of the reason why some parents wait for children to ask them questions other than initiating sex education discussions themselves. They may have a feeling that they would be repeating what children already know from their school.

Another adolescent girl stated that their school invites adolescent reproductive health organizations to complement the efforts by the teachers.

“In my school, apart from the biology class, we once got a special person from a sexual organization who came to talk to us about it one time. But most of the time it was the biology teacher. It was very good, we learned a lot about diseases and how it works. Both boys and girls are taught together. We would read a book and have a test out of it. Everybody was laughing”.

Overall, the school was reported to be instrumental in giving sex education especially from the technical point of view. This has in combination with other social institutions contributed to the low levels of teenage pregnancies in the Netherlands. However, it was criticized for starting sex education late and for being almost solely technical and
theoretical in its approach to sex education. The school supplements the role of parents. But for children whose parents find it difficult to discuss issues of sexuality, late sex education by schools if not supplemented by the information from other sources may be put at disadvantaged position.

Partnership between parents and teachers is considered important. The WHO cited that a realistic perception of the student’s own risks and of the benefits of healthy sexual behaviours is closely related to motivation of the youth to adopt such behaviours. Teachers can disseminate the knowledge but parents and peers may be playing a special role in directly and/or indirectly motivating adolescents to put into practice the knowledge received from the schools.

This observation is in line with the submission made by WHO (1994) that peer reinforcement and support for healthy actions is crucial, as peer norms are powerful motivations of young people’s behaviour. Programs that use peer leaders are effective because peers are likely to be more familiar with youth’s language and culture. Parents can also motivate and reinforce the objectives and play a part in their child’s sexual education.

However, the study findings indicate that there was no formal organization for the peers in schools whose primary role was to foster safe sexual practices. Peers were an informal channel in which adolescents spontaneously share information about all sorts of topics including sex. A formal peer education program may contribute to the development of a partnership between teachers and peers in disseminating sex education messages. These would complement the efforts of each other in building the capacity of adolescents to respond responsibly to their sexual needs.
The Media: Its Role in Shaping Adolescent Sexuality and Prevention of Teenage Pregnancy in the Netherlands

The media is a key actor in information dissemination on all aspects of life. It is a very unique institution for fighting ignorance and presenting information in ways that people can easily comprehend. It can be used to construct and deconstruct social norms and values depending on the realities of the day. In addition, it is renowned for keeping messages simple and clear. It is a very popular and swift way of disseminating information on socially and politically sensitive issues such as sexuality.

The major interest in the media was motivated by the need to explore the its role as a socializing agent for adolescents with special regard to sexual behaviour.

Over the past 12 years, primarily in response to the AIDS pandemic, the government of the Netherlands has invested heavily in the mass media and public education campaigns. These efforts have played a positive and direct role in breaking down societal taboos about discussing protective and risky behaviour (Ketting and Visser in Berne and Huberman et al 1999). Officials in the Netherlands believe that mass media campaigns have distinct advantages over other strategies in that they:

- Keep sexual health on the public agenda;
- Reduce stigma by emphasizing community responsibility for health problems;
- Serve in educating youth by providing catalysts for discussion and by reinforcing messages;
- Rich higher risk groups not generally accessible through traditional channels;
- Encourage intermediaries (teachers, youth workers, pharmacists) to draw attention to safer sex; and
- Stimulates organizations to provide training and education of intermediaries (Broeders and Hasselt 1998, quoted in Berne and Huberman 1999:14).

It is also imperative to note that the Netherlands media campaigns do not work in isolation. This is because experts recognize the need to combine research, the media, and education. The government funds several organizations and projects to collaborate in formulating integrated strategies for delivering safe sex messages through a variety of channels.

According to Berne and Huberman (1999:14), the Dutch government takes a “hands off” approach in the development of strategies for promoting sexual health. It does not attach It attaches no strings or restrictions on content or explicitness. Instead, the government trusts the agencies to develop effective strategies based on research. Continuing research helps the experts to keep abreast of the trends in the population’s knowledge, attitudes, beliefs, skills, behaviours and sexual health outcomes Using this information, agencies develop and implement appropriate campaigns, education and policies.
Ketting (1994: 161-171) documented that in 1988, agencies introduced summer holiday campaigns. This was aimed at increasing safe sex during romances. Packets which contained leaflets, posters, stickers, and condoms were developed and distributed. Brochures used several languages to help Dutch youth negotiate safe sex in languages of potential partners. Schools and intermediary agencies also distributed the packets at youth camps, community organizations and pharmacies throughout the country.

In similar manner, campaigns for 1989 to 1991 focused on excuses for not using condoms. These excuses ranged from “it can’t happen to me”, “I do not use a condom because I only sleep with descent boys or girls”. The 1992-1994 campaigns worked to achieve changes in social norms using the social learning theories, and the theme, “I will have safe sex or no sex”. The 1995 campaign centered on communication skills: “I will take something off if you put something on”. The 1998 campaign focused used the slogan; “STDs are somewhere near you and so are condoms”.

It has been aptly argued that while recent campaigns have focused heavily on prevention of STDs, the Dutch have long supported efforts to prevent unintended pregnancies. The compromise between focusing on STDs and unintended pregnancies resulted into the “Double Dutch” message which encourages sexually active people to employ two methods of protection; the pill to prevent pregnancy and the condom to prevent STDs. It is therefore not surprising that today, 85% of the Dutch adolescents use protection at the first sexual intercourse; 46% use condoms, 13% use oral contraceptives and 24% use Double Dutch- the pill and the condom together (Rademarkers 1998:3).

Berne and Huberman (1999:17) report that in 1997, a government sponsored survey to evaluate the effectiveness of public education campaigns regarding safe sexual behaviour found that:

- From 1987 to 1997, the percentage of persons who used condoms with a casual partner increased from 9 to 58 percent; only 16 percent never used condoms.
- From 1991 to 1997, the percentage who agreed that STDs were a reason to use condoms grew from 67 to 85 percent.
- From 1987 to 1997, the percentage who know that the condoms protect against STDs grew from 74 to 96 percent.
- From 1992 to 1997, those who found it difficult to discuss condoms with a new partner decreased from 18 to seven percent.

(Rademarkers 1998 in Berne and Huberman 1999:17)

It would of course be unrealistic to attribute all these achievements entirely to the role of the media. But the media takes a lot of credit because of its vital coordination role and efforts. The planning and research work may be done by other significant actors but the media plays a very instrumental role in the mobilization and information dissemination. Thus mass media campaigns reached wide audiences through radio, television, cinemas, commercials, outdoor advertising, posters, and leaflets (Breoders and Hasselt 1998).
In line with the above secondary data collected, information from primary sources of the study, indicated that the media plays a pivotal role in educating the youth about sexuality in non-prejudiced ways. Its work is based on the premise that youngsters need to know about sexuality, fertility and contraception to be able to prevent unwanted pregnancies as well STDs. Study participants acknowledged the special role of the media in promoting safe sexual practices through providing a lot of information on youth sexuality. The most important sources of this information are the youth magazines and the television and the radios. Books, posters and brochures were rated of secondary importance.

This finding is similar to that of Ketting (1996:14) who stipulated that a striking characteristic of the Netherlands is the important role the media has played in conveying sex education messages to teenagers. He further stated that for more than two decades, the media have paid much attention to sexuality and related subjects. They usually do it in a frank and explicit way; without being sensational, and avoiding unnecessary technical and concealing language.

He further elucidated that the media have tried to address the questions and issues the youngsters are really interested in, and not to be unnecessarily moralistic and paternalistic.

**The television and radio**

The most popular television centres for adolescents were SBS and Veronica. They communicate sexual information in form of commercials promoting the use of condoms and contraceptive pills. They were applauded for showing different aspects of sex; safe sex and other positive values like care, respect and compassion. This is done through movies and talk shows which educate young people about different subjects related to sex.

However, they are criticised for showing late at night. Some adolescents observed that they like the shows but they are aired very late in the night. This makes it difficult for them to watch some of these programs. Some were of the view that television shows go over board. They show too much especially if they are being watched by children of less than 8 years who may have a low absorptive capacity for such shows. But some maintain that it is important for these children to know facts about sex as early as possible. Below are some of the responses or opinions about the television as an instrument of sex education and/or socialization.

A boy, 19-year old high school student noted that:

"You have commercials about safe sex. You have sex programmes. You have talk shows about sex and their they discuss what women and men like and what you have to do. How you have to protect yourself against diseases - condoms, the disease killing pastor. But it is an old programme. During the movie, you have commercial breaks and then you say oh, that is good. Veronica and SBS are the most popular TV centres. But Veronica is better for the youth".
In addition, another boy, 19 years old, a first year university student pointed out that campaigns for sex education and condom use in particular are launched every year on the television and radio by the ministry of health and the Rutgerstichting.

“Yes there are campaigns here, specially launched every year. There is one about; you have to always use a condom. You should not wait till too late. There is also one which warns about the diseases you can get out of the unprotected sex. It is called - ‘Condoms you can get everywhere, disease you can get everywhere’. They primarily target diseases and not so much pregnancy. The radio programs target the youth, they are very funny and they really appeal to the youth. From 5 - 8 p.m., for example, you have a radio program - you can write questions about sex to the centre. They find an expert on that question and she explains it to you. They give a couple of answers about how to enjoy sex better with your partner. It makes the points very clear but in a funny way. It is very effective. Using a condom is portrayed to be normal and not exceptional”.

This opinion is in consonance with what is documented by Rademarkers (1998) and Berne and Huberman (1999) as mentioned above.

Furthermore, a 20 years old, first year female university student noted that:

“I feel in Holland every one talks non-stop about sex. I think that we are so much busy with sexual intercourse. Sometimes I think it is over the board. Sometimes when I see it on the TV, I say oh! my God, we are too sexy”.

In addition, in a focus group discussion with five girls aged between 15 and 21 years, they made the following remarks:

Interviewer, What is your opinion about the television shows on sex?
B: there are Talk shows about teenage pregnancies.
C: American talk shows aren’t open. This makes them stupid.
B: But there are sex shows on TV and they are showing and discussing everything like sadomasochism. The popular TV centres are SBS and Veronica
D: It is too late when they are showing. I find it a problems waiting to see them.
D: The Netherlands is a free country, you can do everything, say everything, it is not secretive but sometimes it is too free and too much. It is too early for certain children to watch such open shows. I have a little brother and sometimes they show things which I feel are too much for him to see at that age. Very early in the evening, they are screening erotica. He is only seven years, he is too young for it.

B: but they will watch it. I think it is good for kids to learn at a young age. If you look at America where children are barred from watching them, there are many problems like AIDS and teenage pregnancies. If they do not know about it, they may be abused by baby sitters. I do not think that soft pornography shows are bad for children. Commercials are good for them. I think education is okay but if it is for entertainment then I is not good.

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C: Americans are proud, they do everything but they do not want to talk about it.

In the same vein, a young woman, 19 years old, first year university student observed that it is very rare to find someone living in the Netherlands who is not informed about safe sexual practices. She felt that the media, through the television and radio and the newspapers reach almost everybody.

"Everybody watches television and reads a newspaper once and listens to the radio. You have to be very ignorant not to pick anything out of this. You must be closing your eyes and ears if you know nothing about these issues".

The findings above attempt to confirm that the media through the radio and television is playing a significant role in educating the youth about both technical and practically sound issues that are relevant to the sexual needs of adolescents. The shows are perceived to be very open to an extent that some people feel that they go inappropriate for certain audience, especially the very young children. Some television programmes however were criticised for showing very late. The television and radio messages may therefore have a contribution to the low levels of teenage pregnancies in the Netherlands.

Magazines

It was established during the course of executing the study that youth magazines like "Yes", "fancy", "hitcrant", "breakout" and a host of others are very popular among adolescents especially the girls. However, they are more popular for adolescents of quite young ages like between 13 and 16 years. When girls become seventeen and above, they develop a feeling that the magazines are quite childish, for beginners. Some start thinking that the stories are "made-up" not real. But overall they perceived magazines as a fascinating source of information for the youth. Most of them acknowledge that magazines bridge the gap that is not thoroughly covered by parents and teachers.

It is also a good stimulant of discussions among peers. They have very interesting stories about experiences of other youth not only in the area of protected sex but also other positive values of sex. Adolescents can also share their experiences with others anonymously. They provide an avenue which adolescents can use to ask very sensitive questions anonymously. Most informants who were between 15 and 16 years had very good opinions about magazines. It is the older ones of 18 years and above who felt that they are no longer that useful to them because they already know what the magazines are talking about and they find some of the stories as just exaggerated.

Some of them were of the opinion that magazines are biased in their information about contraception, they never give enough information if any at all on the negative effects of contraceptive pills and other methods. However apart from such criticisms, almost all study participants acknowledged that magazines play a vital role in educating adolescents
about sexuality and how one can learn from the experiences of others to cope better with their own sexual problems.
To confirm what has been stipulated above, a few verbatim quotations recorded from study participants are here below.

A girl of 20 years who is currently in high school made the observation that magazines handle the real day to day sexual challenges that adolescents face. They were hailed for being down to earth in their messages to the youth. She said:

“We also have a lot of girls magazines. For young girls. They are about fashion, stars, beauty and sexual relationships, feelings and I think I learned a great deal about the emotional side of safe sex from these magazines because in school you learn, that if you go to bed with someone you use a condom to prevent from getting pregnant. In magazines, it is said well it may be very difficult for you because a guy can persist that he wants to go to bed with you without condoms. You may fall in love and forget or you might think, well I am using the contraceptive pill. It talks about practical issues. So I have read the magazines a lot. I get familiar with it so when the time comes I know how to deal with this question”.

She further noted that magazines are not only easy to identify with but they are also cheap and convenient for adolescents compared to the school, television and radio programs:

“For ordinary girls magazines are very useful information. In films or movies, you know you can’t identify with these people. It is extreme or you know it is not real, it is by actors. It is very nice with the magazines and convenient. If you do not want to read it at a particular time you can put it away and turn to it later. If you like to read it or you are interested, you grab it. You can take the information at your own time and pace. At school, you have to learn, you have to follow strict programs. For the television, when the program is over, you have may be just half and hour program. We have a lot of magazines. They range between $2.50 and $6.00. You get them if you are curious. You can also go to the library and read them from there. There are lots of magazines in the library”.

Another girl of 20 years, a first year University student made the following observation that the educational value of magazines becomes lesser and lesser as they grow older probably have more sexual experiences. She remarked:

“Probably, magazines give you some vision of what to expect later. They surely contribute to your shaping your sexual perceptions. I, at this time of my life, do not read magazines, I read them when I was like between 12 and 15 years. You got like the Tina, Fifi, Flare and Mari Claire. Those kind of magazines which make everything so great. That is not where my interest lies anymore. But during that age, they contributed to my vision on what it will be, but this when I hadn’t got any experience. Educational value became lesser with the increase in my age”.
But in a rather very quick turn, she precisely stipulated that magazines are more about the quality of your sexual life, not really about sex education especially when you grow a bit older.

"The magazines, for me are not necessarily about sex education. The things you know from the magazines are more of the different positions you can take. The issue was not to learn about protection because I knew about this but to learn other qualities of sexual life"...

When I asked her about the limitations of magazines, she instead responded by discussing the perceived strengths of the magazines:

"No, because you can write to them anonymously, so nobody has to know what you want to know. Even then not all the questions are being published. You always get an answer and you get it at home. And especially if you have got big problems, they can point you out and they will help you with services you can use as you get there. But most people know that if you have got a question and you do not want to ask it to your parents, peers, or teachers at school, that is an anonymous way to ask that question".

In the same vein, one of the key informants, a research fellow in adolescent reproductive health forcefully argued that,

"Magazines are very good at handling adolescent reproductive health topics. People are free to ask questions related to sex and send them by post. The magazines are always very positive about contraceptives. Whatever the side effects, the magazines would mostly give the answer; do not worry, you will get over it. They say just use the pill. It is really terrible. Even when there are questions about say reducing sexual arousal, they just say that may be but there is little chance that the pill is the cause. Just go on using it. But maybe after some years probably you could stop".

In another case, an 18 year old high school student remarked that magazines are just superficial in the information they offer.

"My friends do read magazines. They contain some information about sex. I know magazines like Fifa, Fancy, Yes, I know it but I think it is rubbish. I would rather read a book or something. But sometimes when I am really tired, I read it. If you do not have to think about anything. You know, it is so easy. It is only when you really tired and relaxing like watching MTV. In front of your television that you read them. I have not myself found them interesting and useful as a source of sex education".

In FGD with five girls aged between 15 and 20 years the following responses were enlisted about the weaknesses and strength of magazines as a sex education channel.

One of the FGD participants, 17 years said:
"There are columns in magazines where questions about sex from adolescents are answered. They tackle lots of questions, sometimes strange questions. Sometimes I think they are made up questions. Strange, you know it but they claim not to know it. Questions like masturbating with a sausage".

However another participant, aged 16, hailed magazines by stipulating that they bridge the gap not covered by some parents and they are anonymous. She noted that:

"You can ask questions and be anonymous, you do not have to sign anywhere. It is less embarrassing than to talk to your parents. Some people can ask questions and share their experiences anonymously".

It is imperative to note that those between 15 and 16 were more supportive and interested in magazines than the older adolescents especially in this FGD. Age might thus contribute to the differences in opinion and perception of sexual education value obtained from the magazines.

In another FGD with boys, magazines weren’t rated highly. However, only two out of the eight boys said that magazines are useful:

"Magazines like break out are useful because they do have a column on sex. You can send questions to them and you will get answers".

"You can read about other peoples experiences, how they think about sex".

On the whole, girls seemed to have more interest in magazines than boys. It may be that magazines target issues of much greater interest to the girls than to the boys. A lot of information in the reproductive health arena gives more emphasis to problems of girls and women in general than the men. This might be because girls are perceived to be more vulnerable than the boys. Girls also carry most of the burden when it comes to issues of pregnancy and contraception. It may not be just a problem of magazines but a problem cutting across the information reservoir of reproductive health issues. Magazines as stated earlier were described and assessed to be more useful to adolescents between the age of 12 and 16 than to those beyond this age in terms of sex education value. Older adolescents perceive them as useful not for safer sex education but basically for improving the quality of their sex life. This may largely be attributed to differences in sexual experiences between the young and older adolescents.

Magazines are criticized in certain circles of especially older adolescents for stage-managing certain questions. Some adolescents felt that magazines sometimes may just create questions. However, it can be argued that these are just alleged propositions, there is no concrete data to verify them.

In a nutshell, the magazines were found to be of utmost importance in giving practical information to adolescents about sex. They enabled adolescents not only to ask questions
but also to share their experience and those of their peers anonymously. It bridges the gaps left by the parents and the schools. In addition they were rated to be one of the cheapest and most convenient sources of information for adolescents. It is mostly the older adolescents who had a low opinion of them. This could be explained by the fact that these adolescents may have already known and experienced most of what is communicated in the magazines. So their educative value diminishes. Such adolescents would just read them for fun and just to get little information on how to spice their sexual life.

Thus the media was rated as a strong socializing agent in the realm of adolescent sexuality especially in regard to the prevention of teenage pregnancies and STDs. The teenage magazines and the television were ranked highly as the major media channels through which adolescents are provided with information to enable them to cope better with sexuality at this development phase which child psychologists describe as a stage of "storm and stress". It is only simple non-prejudicial information that is adjusted to the practical day to day experiences of adolescents rather than solely technical information that can facilitate adolescents to embrace responsible sexual behaviour. It "de-storms" and "de-stresses" the reactions of adolescents to sexuality thus enabling them to cope with adolescent sexual life, and respond to issues such as teenage pregnancies, abortions and STDs.

Poster
The Church: Does it Play a Role in the Sexual Socialization of Adolescents in the Netherlands?

Another interest of this study was to learn about the role of religious institutions in shaping and transmitting values and beliefs about sexuality, reproduction and family formation and how this relates to the teenage pregnancy situation in the Netherlands. The study also explored whether religious institutions especially the church influence sexual health policies and programs in the Netherlands.

Historically, the Netherlands is largely Christian, mostly dominated by the Protestant and Catholic religious denominations. In addition, there are also people who embrace Islam and other religious faith. For purposes of this study, my interest was limited to the role of the church in shaping sexual behaviour of adolescents and contraceptive use. I wanted to establish the role of the church in contributing to the low levels of teenage pregnancy in the Netherlands. This is because elsewhere especially in the southern countries, it has been documented that the policies of the Catholic church combine with other forces of conservatism to discourage people from using contraception, and to influence people’s perceptions of teenage sexuality. The church may not be the major factor in influencing sexual behaviour in these areas but forces of conservatism may exploit its policies to further dissuade people from adopting the use of modern contraceptive methods. They may also make people to send confusing signals and to portray double standards about sexuality to the adolescents. This may make adolescents to become easy prey to teenage pregnancies and STDs.

During the course of the study, it was established that religion is playing a marginal role in contemporary Netherlands. All study participants contended that the role of the church has sharply declined in influencing most aspects of life including sexuality. According to the Berne and Huberman (1999:60) currently about 40 percent of the Dutch citizens acknowledge no religious affiliation or attend any religious services. It was however stipulated that before the 1960s, the church’s influence on the moral and sexual behaviour of the people was in significant proportions. In line with this opinion, Ketting (1996:13) noted that internalization of the a morality of self sexual restraint has been a major cultural strategy in the western society during the past two centuries. He added that backed up by moral and religious teachings, several generations have been raised with images of sexuality as inherently bad, dangerous, sinful and unhealthy. In this strategy, the primary mechanism of control in avoiding untimely sexual behaviour of adolescents is self-restraint through feelings of shame, guilt and fear.

The sexual revolution of the 1960s and 1970s also played a role in the declining influence of religious institutions. People saw that reproductive rights for women of all ages was central to their civil rights. Values began to shift away from a religious basis towards an individual ethic supporting women’s ability to be equal partners in relationships and their ability to participate in the work force. These reproductive rights extended to young women over the age of 15 (Berne and Huberman 1999:61).
With the declining role of organized religious efforts, the family, schools, and the media became important in transmitting values around sexuality. The above authors documented that religious institutions in the Netherlands, France and Germany recognize that their teachings must be consonant with changing social values and mores in order to be accepted as relevant. Thus, while religious institutions in these countries may not support a particular philosophy or practice, they accept that individuals may not abide by the dictates of the church.

In the same vein, it has been articulated that individual freedom and responsibility are important values to the Dutch. Morality of sexual behaviour is weighed through an individual ethic and that includes values of individual responsibility, love, respect, tolerance, and equity. Morality is not a result of collective force such as religious dogma. Overall, Berne and Huberman aptly observed that the major religious institutions do not seek to control public policy or to stifle research based programs in Netherlands, France and Germany.

This implies that many of the religious institutions of countries like the Netherlands either maintain neutrality or quietly support programs and policies which improve the sexual health of the population, including adolescents. It also elucidates that public policy about sexuality and sexual health is more often dictated by pragmatism and research than religious dogmatism and Puritanism.

In the same vein, one of the key informants working with the Rutgerstichting in Utrecht observed that;

“If there is a country where religion is very strong, the behaviour of the people has to follow the religion. If religion says that no sex for people till they are married, we have to follow the rules of the religious leaders. But that is what they want and the young people have their own ideas. They have feelings and young people do fall in love but everything goes secret. Young people will say, I believe but I do not have to follow all those rules. If parents forbid sex, then young people to be respectful to their parents do it secretly because in the open it is a problem. If the school policy is no relationships, the young people will indulge in them secretly”.

In addition, she noted that the influence of the clergy in the Netherlands is on the decline most especially in the major cities. She said:

“In Holland the declining power of religious leaders is more in the big cities than in the country side. There you find villages where there are still rules like, no sex before marriage. We had this before but over the last 20 years, a lot has changed. I think that one of the important things is that religion goes to the background. So young people can develop better and access to young people. 25 years ago it was difficult for a young unmarried girl to get access to the pill because the doctor asked her whether she was married”.

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In other words, she was trying to imply that 25 years ago, moralistic and paternalistic attitudes and prejudices were still the rule of the day but to date a lot has changed in Holland especially in the urban centres.

In a similar manner, another key informant, the research coordinator of NISSO made the following submission:

“One thing which is very important is that the church doesn’t have a major influence in the Netherlands on behavioural aspects. Most of the time the church elsewhere doesn’t have an effect on sexual behaviour but it does have an effect on the contraceptive behaviour. Because they feel guilty about sexuality and they are not allowed to do it; young people cannot ask questions about it to any one. Therefore they will not use condoms or the pills because it is not so easy for them than the country like Netherlands where they are allowed to have sex and they can do it in a responsible way”.

In addition, she explicitly gave a historical insight into the dynamics the church influence in the Netherlands:

“In the 60s, the Netherlands was very much influenced by the church and then you saw that I think fewer people had pre-marital intercourse, but the ones who did got pregnant or other kinds of problems because it was not allowed- so it was not in the open. That is important, when you can be open about it you are better informed about what to do. When you are not informed, for example, a lot of teenagers may not know a lot of things about STDs and they would have sex with a lot of risks”.

In his analysis, Ketting (1996:13) contends that encouraging positive and responsible behaviour as a strategy has gradually evolved in some parts of the western society during the past decades. The right to explore and experience sexuality is basically admitted to the adolescents. At the same time it is admitted that sexuality during adolescence is also a learning process, that needs continuous education, guidance and some assistance in order to develop in a positive way and to a void some potential risks.

This strategy has been developed and implemented to some extent in the Netherlands during the past two decades. Since the implementation of this strategy, it has been documented that from a comparatively low level of 28 per 1000 in 1970 to around 10 per 1000 in 1990. Pregnancies among girls under sixteen years of age are almost non-existent in the Netherlands. This rate is more than ten times as low as that in Britain and the United States. The rates of teenage pregnancy in Britain and the USA is blamed on the culture of ambivalence prevalent in these countries. That is, they are halfway between the repressive attitude regarding adolescent sexuality and acceptance of the strategy of encouraging positive and responsible sexual behaviour.

It is by making organized efforts towards abandoning this ‘lukewarm’ attitude towards young people’s sexuality and adopting a pragmatic approach that reflects the sexual needs
of the adolescents that the Netherlands has made a headway in preventing teenage pregnancies while in other parts of the globe teenage pregnancies remain a problem.

It is noteworthy that most of the opinions of the other study participants were more or less similar to those of the key informants and to what is already documented in the literature. For example, in a focus group discussion with boys, the following opinions were elicited:

'It depends on how you believe in the church'
'It depends on where you live in Holland'.
'It is a bit stupid on the other hand. The Pope says no to abortion; you get raped and you have a child whom you did not'.
'The role of religion in shaping sexual behaviour is declining because there are not so many people who go to church. The new generation is easier because the parents are gonna get easier every generation'.
'My grandparents were going to church every Sunday, my parents seldom go there and I never go'.

All these responses were pointing to the fact that religious activities in the Netherlands has declined. This may largely imply that it is quite a small section of the population especially in the countryside who still highly committed to more or less conservative religious values that influence their sexual and contraceptive behaviour.

Furthermore, in an interview with a 20-year old girl who studies in University student, she clearly disassociated her sexual behaviour from any church influence. She is quoted to have said:

"I have been raised as a Catholic and when I grew up I began to wonder about my beliefs. I now have my doubts about the Catholic church. I do not also attend the Catholic church. I do not also worry that there is a hell waiting for me when I sin. Actually the church has been a non-issue in my sexual behaviour".

In the same vein, a boy of 19 years old who is also a university student, made the observation that the influence of the church is declining.

"Here the churches are more of souvenirs from the past. Each year, its influence declines, less people go to church. Its impact is thus less. Here people are Catholic or Protestants but they do not necessarily go to church. So this creates a difference in the promotion and use of condoms".

However, one parent observed that there are some people who still believe in religion and the sexual behaviour of their children has been shaped accordingly.

"I have a friend, she is very religious. She has three children. We have the same values but hers come from the Bible and mine come from myself. Her daughter is 17. She has a very different opinion from me because her children should not have sex before marriage."
The old boy married three months ago. He was 23 and the girl was 22. But generally, I think that the church is losing influence. For me the case above is an exception because my other friends are not religious. The group influenced by the church is becoming smaller and smaller.

On the whole, whereas people did not completely discard the role of the church in shaping sexuality else where, they largely felt that its role in shaping sexual behaviour has been reduced considerably. This may explain why contraceptive use in the Netherlands is not viewed in terms moral and religious paradigms. It is rather perceived from pragmatic paradigms that have historically characterized the Netherlands in its social and economic policies.

In line with this argument, Ketting made the following statement:

Unlike our German neighbours, we do not philosophize or moralize at lengths. This might be related to our long history as a trading nation: we learnt to adopt to other cultures, different value systems, unexpected ways of behaviour in order to make a profit. When the problem of teenage pregnancy became prominent in the 1960s, the Dutch society therefore tended to look for practical solutions. Such a solution had just become available: the pill. So why shouldn’t it be applied vigorously? It worked!"

Thus moral and religious prejudices were gradually put aside in order to arrest the problem of teenage pregnancies. The state and the civil society worked in partnership to promote the pill. It became popular and the fruits today are the low levels of teenage pregnancies in the Netherlands.

The role of service providers in preventing teenage pregnancies and promoting responsible sexual behaviour

Service providers have basically been classified into two; the general practitioners (GPs) and workers in reproductive health organizations such as the Rutgerstichting. The Rutgerstichting or Foundation, the Netherlands affiliate of IPPF(International Planned Parenthood Federation) in working in the area of sexual and reproductive health. Its way of working is characterized by a positive approach to sexuality, an up to date knowledge of sexual and reproductive health issues and a personal involvement and professional commitment towards the recognition and implementation of the sexual and reproductive rights of all human beings, especially young people and women worldwide. It offers a wide range of sexual and reproductive health services such as medical consultation, psychosexual services, information by telephone, training and education courses and information brochures.

According to Berne and Huberman (1999:29), the Rutgers foundation has implemented a number of strategies to make services more welcoming and friendly to young people. The teen strategies employed at Rutgers clinics include:
• Accept teen sexuality and sexual behaviour;
• Guarantee anonymity or confidentiality;
• Waive PAP smear and pelvic examinations as prerequisites for contraception;
• Provide non-judgmental service;
• Require minimal paperwork; and
• Require no parental consent.

In the Netherlands health care system, the general practitioner (usually called the “family
doctor”) is by far the most important service provider and he or she meets these criteria. It
is well known that she or he provides family planning services; s/he feels highly
responsible for the prevention of unwanted pregnancy and abortion; in “his” patients he
lives and works “just around the corner”; his services are free of charge for those enrolled
in the national health insurance scheme and he is usually well known and trusted by his
patients. His service to minors is confidential. Girls who do not want their parents to
know about their sexual relationships do not have to be afraid that the family doctor will
tell them Ketting (1996:15).

Thus first point of contact in terms of health issues between the family and the state or to
be more specific the ministry of health is the GP. They are consulted and if the problem is
serious, they refer the patients and/ or clients to the relevant specialists. The GPs make
prescriptions for people to buy medicines from the pharmacies.

Study findings showed that the major role of GPs is in the area of prescribing pills for the
adolescents. They are the go between the pharmacies and the adolescents. Girls in most
cases have to get a prescription from the doctor in order to obtain the pills from the
pharmacies. All the girls interviewed were aware of the policy that they can obtain the
pills from the GP without the GPs necessarily informing their parents. They reported that
their interactions with the GPs were fine and the services were not provided with
prejudices. The GPs ask for the reason for the pill in order to establish the best pill that
suits the adolescent. It was also stipulated that the process is simple, not involving a lot of
questions and physical examination. Girls generally had positive opinions about
GPs. Some of them, however said that they would be more comfortable with female than male
GPs.

This study result is similar that of Berne and Huberman (1999:30) who noted that:

“Since the 1960s, family practice physicians have energetically developed
communication skills and mutual trust with Dutch adolescents. The family physician
receives regular training to improve communication with young patients and see the
sexual health of young people as a major responsibility”.

However, it was noted by all the adolescents interviewed that the GPs are not responsible
for giving sex education. They may have some brochures or fliers but they do not make
any attempts to give one sex education. Adolescents felt that their major function was to
establish the right pill after their diagnosis of the nature of their problem. They however
noted that if adolescents had any questions, they would feel free to ask the GPs but in reality this is quite rare. The main questions they may probably ask are the technical issues pertaining to the pills in order to allay their fears about any paradoxes.

For example, during an interview with an 18-year old girl, she noted that the GPs are too busy with many patients that it becomes inconvenient to ask them questions about sex. She said that in such circumstances you would go the Rutgerstichting for information about your sexual paradoxes. She is noted that the Rutgerstichting would offer you almost all the services you need. She also emphasized the confidentiality of both the GPs and the Rutgerstichting officials.

In another case, a girl of 19 years observed that their family doctor gave her some sex education although it focuses mainly in the efficacy of the pill and on the need to use condoms for protection against STDs. This may suggest that GPs mostly deal with advice on the pills and other contraceptives that might be relevant in a certain situation.

In an FGD with two girls and two boys, one of the girls, 16 years old was quoted to have said that:

"I think the services are very good. At the moment you are laughing about it but later you would think about it and say oh! I did not know this. You can get the pills easily from the family doctor. The Rutgerstichting are especially good because you can go with your case and talk about it with them. They have experience with these kind of problems".

However, in the FGDs with the girls only, one girl in an emotional note made an observation that some GPs evade the privacy of some girls by telling their parents about their requests for contraceptive pills without the permission of the girls. She relayed this based on her own experience:

"I went to our family doctor, I wanted to get the pill without the knowledge of my parents but the family doctor to my surprise told my parents. That day I felt shy and devastated. It is something I least expected to happen. My parents were surprised that I couldn't tell them this before but anyway, after a small argument we put the issue to rest".

All the other girls were surprised to hear that because they felt that this is a policy which is law, order and binding. It was perceived as a violation of professional ethics. Despite the fact that it is only one case, it is a serious malpractice and contravenes the policy and confidentiality as one of the major qualities of the GPs. However, the mere fact that all other girls were very surprised may suggest that such an anomaly rarely happens.

It thus becomes one of the ostensible reasons as to why there should be other alternatives to which young girls can turn to in case they are frustrated by such an ethically competent GPs. This is when the Rutgerstichting becomes one of the significant alternatives to solve the above discrepancy in the delivery of adolescent reproductive health services.
For example, in an interview with one of the doctors at the Rutgerstichting, she observed that in the Netherlands, contraception is easily available, you can go to a house doctor and will give you prescription without telling your parents. People know that the family doctor has an obligation to be silent against the parents. Even you can send him to prison if he is a bit rough, if he would break this ethic. She however hastened to add that:

"But there are lots of girls who say, I am not going to family doctor because the neighbour is sitting in the waiting room, and then everybody knows what I am going to do there with the family doctor. So they may have to look for another place to get the pill or prescription. In such cases the Rutgerstichting is there to offer assistance to such girls. They come because they want to be anonymous. They are afraid that their family doctor will tell their parents or they do not want to go to their GP because he is a man. They may also say, I went to the family doctor, he just gave me this package; so I do not know how to deal with it".

In a similar case, one of the adolescents, a high school student, 20 years old noted that some girls could feel uncomfortable to discuss sexually intimate issues about their reproductive health problems with male GPs and gynecologists:

"I feel tensed and uncomfortable to explain to a male GP intimate issues about my reproductive health. I wish the government would encourage training of more female GPs".

In support of the arguments above by the Rutgerstichting doctor and the adolescent girls, Ketting (1996:15) documented that:

"It is particularly important for the girls to have an alternative to the GPs. The family planning clinics of the Rutgers Foundation (the Dutch Family Planning Association) provides this alternative. They are highly specialized in serving young people".

In another development, the doctor working with the Rutgerstichting mentioned above made a remark on the utilization of her organization services by gender. She observed that more women than men come for their services. She cogitated that the reason but be located among the historical factors. In her own words, she said:

"Almost 90% of the clients we see are females. The males seldom come to seek services from this organization. Most of the time the males come with erection and early ejaculation problems. Maybe it is because in the olden days the Rutgerstichting was there for the pill".

In addition, she observed that most of the time the girls come alone to seek their services because they have phobia to make an expose of their feelings in the presence of their boyfriends. In fact during my visits to the Rutgerstichting, I observed that the boys would escort their girlfriends but they would remain outside and wait for them there. It could be that their presence would interfere with the purposeful expression of feelings by their
girlfriends. Thus as a matter of respect of privacy and confidentiality they chose to stay out side but give indirect emotional support to the decisions of their girlfriends.

About the quality of their services, the personnel from Rutgerstitching noted that the quality of care is good but hastened to add that lots of foreign groups who are on rather a lower social group have ostensibly declined in seeking services from their institution. She observed that the major reason for this is that the government withdrew most of its subsidies to the organization. She aptly stated that the consultation which was free of charge before now costs 45 guilders (23 US dollars for 15 minutes and if you need a test for STDs you have to pay the laboratory fees yourself). Except when you have insurance, then it will pay for the laboratory cost but the consultation costs will be paid by the client him/herself. The young people below 18 pay half the price, they are partly subsidizes by the government but it is still a lot of money.

The current policy is that everybody can come here as long as they can pay, we do not give services for free any longer. Most foreign groups do not visit us any longer since the withdrawal of the subsidies.

However, Berne and Huberman (1999:31) noted that small fees are charged because teens understand that they must take responsibility for their sex life. He further observes that while the standard clinic fee is about eight dollars (U.S.), if a client can not pay, she or he will not be turned a way.

Similarly, Ketting (1996:15) stated that the Ministry of Health subsidizes the Rutgers Foundation particularly its services to the youngsters under 18 years old. However, the service is not completely free and the clients have to pay for their own contraceptive supplies. In addition, he hastens to contend that although these clinics are still an important alternative to the family doctor, their role has significantly diminished over the past twenty years. This has probably been a consequence of the growing acceptability and accessibility of the family doctors as the primary service as well as the declining trend of teenage pregnancies.

Notwithstanding a few specific criticisms above, reproductive health workers and services were applauded to be one of the decisive factors in reducing the risk of teenage pregnancy in the Netherlands. The three essentials in this respect, accessibility, acceptability and confidentiality were ranked highly among the adolescents and other study participants with just a few exceptions highlighted above. The easy availability of reproductive health services in the Netherlands contributes to the sexual health and low teenage pregnancies among the Dutch youth. Dutch methods seem to have excellent access to the best methods of protecting themselves. Sexually active teens encounter non-judgmental attitudes and strong adult conviction that young people must be sexually responsible. Services are to large extent confidential and free or relatively low cost.
Cost and Popularity of the Pills and condoms

The pill is very popular among adolescents, parents and general practitioners. It serves both as a medicine and instrument of birth control. It has been accepted by doctors and adolescents as vital for regulating menstruation and for reducing its side effects like back pains and stomach cramps. Most of the adolescents interviewed who were sexually active use both the pills and the condoms. The pill is used for birth control while the condom is used for protection against AIDS and other STDs. The condom is very popular among adolescents especially the boys. They take it to be a very important and effective protection against STDs. Most of the boys interviewed complained about the cost of the condom. To them it is too expensive and yet they have to use it. Boys felt that it is very unfair for pills to be covered by insurance while condoms which have a double role are left out of this. They felt that their needs had been marginalized by this policy.

In one of the FGDs, one of the boys said:

"The condoms are very expensive. They cost five guilders for a packet of three. This may affect their utilization by some of the young people".

In the FGD with boys, they also mentioned their disappointment about the price of condoms. They felt that it was some kind of negative discrimination against them by the Ministry of Health. One of them is quoted to have made a remark which to which other participants in the FGD agreed:

"The price of condoms is very high. Twelve condoms cost 20 guilders. If the prices goes down, it helps everybody to use it. It should also go to your social security or insurance like the pill is for the girls. It is unfair for the girls get free pills while boys pay high prices for the condoms".

However, one of the boys, 19 years old, a first year university student had an alternative view about the price. He is quoted to have said:

"You buy a packet with 10 condoms at around 20 guilders. But I would not rate this as very expensive but they cost something. They are affordable. At the machines three (condoms) cost 5 guilders. The price is not as high as to inhibit people from using condoms".

However, most of the girls felt that the price of condoms was okay. One of them is quoted to have said:

"If you want pleasure, you should be prepared to pay for it. Compared to what one gains from the condom in terms of protection, I can not rate its current price as expensive".

This might be because fewer girls than boys do buy the condoms. The boys may be bearing most of the burden for the condoms. The boys who said that the price is not so
high were older adolescents, 19-20 years. This could be explained by the fact that these boys may be earning more money than the young adolescents who are below the age of 18 years. So the differences in opinion could reflect the differences in levels of earning. There could also be an uphill task on the part of young adolescents with no gainful employment to ask their parents for money for specifically buying condoms.

All the adolescents interviewed said that the condoms are available everywhere. Thus accessibility in terms of availability was not seen as a problem. They were also happy about the confidentiality ushered in by the introduction of condom vending machines. This made the condom services both available and confidential.

During one of my field observation, I noted that many young men get condoms from vending machines in bars, disco places and cinema halls at the city centre. Most adolescents both boys and girls recommended for installation of more vending machines for condoms.

However, some adolescents complained that the vending machines are sometimes empty. They said that this can be very disappointing because you would have to move from one cafe to another on a condom hunting spree. Some however, get their condoms directly from the supermarkets. They observed that, it is quite embarrassing but they need the condoms, there is thus no need for fear to overrun their rationality and needs.

It is worthy to note that some adolescents made the observation that condom vending machines are reducing in number. One of the boys, 19 years was quoted to have lamented that:

"Five years or six years ago, they had machines on the streets but they are now not available. I think this is because people would vandalize and take the money. Every bar in Amsterdam had a condom machine".

Some adolescents with stable relationships for one to two years reported that were only using the pills. Some claimed that they were both virgins at the first sexual contact while others had HIV tests every after six months. They trusted their partners not having multiple sexual relations. And for one of them, the condom was irritating. For example, a girl of 20 years who is a student at a teacher training institution noted that:

"From the beginning it was clear to us that if we had sex, it had to be safe. Because I was so scared I would get pregnant. Diseases were not so much a problem because we were the first for each other. This was a good feeling. This was something special, maybe we don't stay together for all our lives but I would always remember him for being my first special boyfriend. I had the pill and that was only for prevention of pregnancy. As for the condoms, we never use them. It is so irritating. We went through it one time but it did not work out for me very good and it was interrupting so we only use the pill".

In the same manner, a 20-year old girl from a university made the following observation:
“No, when I first tried it out, my boyfriend was of course inexperienced, and I have always practiced safe sex, till I knew I did not have to use a condom anymore”.

Another participant, a young boy, reported that for him and his girlfriend the pill would be enough but they would use the condom for hygienic purposes. In his own remarks he said:

“My girlfriend was comfortable with it; because when my sperms go to her vagina, they leave a mess, she says. If we use condoms, she doesn’t have to clean it up. It is just so easy, for convenience”.

The other girls felt that using condoms is a form of respect by their boyfriends to them. They felt that if a guy does respect a girl, the issue of using condoms is not negotiable. They had the slogan, “no condoms no sex”. For instance, a girl who is 20 years old, said that:

“Oh! once I was starting to have this relationship thing with another person and when I asked about the condoms, he was reluctant to use them. I bluntly told him to back off. Guys have to learn to respect their girlfriends”.

In this case a guy’s reluctance to use a condom was interpreted as disrespect by the girl with whom they were dating. There could be a clutter developing among girls that equates safe sex with respect of the girl by the boy. However, as already pointed out this is a dynamic issue, it is relative from one relationship to another. The major issue to note here is that there is a growing popularity for protected sex among both the boys and girls. This of course tends to diminish in some couples as they stay longer in the relationships.

It was established that the pill is not only used for birth control but also as medicine by young adolescents for their skin or for menstrual regulation and/or averting the side effects of menstruation such as stomach cramps and headaches. This attitude has bolstered its popularity among adolescents and also relaxed the former sexual attitudes attached to it. Most adolescents said that now pills are separated from sexuality because they are multi-purpose. Before becoming sexually active, data from both secondary and primary sources suggest that a good proportion of adolescents would be using the pill. When they become sexually active it takes on two functions: Regulation of menstruation and birth control.

It was also established the girls were positively motivated the exclusion of mandatory internal examination on request of the pill from the GP. They said that such an examination would make them scared. It might have been a reason not to go to the doctor. Until ten year ago this was a requirement for getting the pill. This made some girls avoid going to their family doctors in preference of doctors from other cities. This was a major breakthrough for some adolescents who felt constrained by such a policy.
This finding is in line with Ketting's position that the immediate reason for the reduction of teenage pregnancies has clearly been a considerable improvement of contraceptive use. However, inspite of this overwhelming popularity of the pill, it was noted at the first intercourse, some adolescents do not use any form of contraception. Coital debut thus remains quite risky. The incidence of non-use of contraception was, however, reported to have sharply declined from an estimated 42% in 1968 to 11% by 1981. The reason for this decline is that if risks have been taken at the very first intercourse, contraceptive use improved shortly after that occasion. Ketting contends that an important reason for the delay by girls to use contraception is that by taking the pill, girls sometimes feel that they present themselves as wanting to have sex.

During the course of the study I came across some evidence to support his claim. For example a girl of 18 years old is quoted to have said:

"When the doctor told me to get the pill I thought or not me I am just 13 years old. I thought it was about pregnancy and I never thought that it is for the stomach pain. I thought okay? What is happening to me. I am only 13 years and I am beginning to think about sex and boyfriends but not doing it. I think about how it will be but now the doctor is giving me the pill, I was so surprised".

In another interview, one of the key informants, a researcher fellow, made the following remark:

"There are several reasons why adolescents use the pill. One of them is menstrual problems. If one is having some menstrual side-effects like headaches, they can be applied. You just go to the doctor, and you say, I have menstrual problems and the doctor will prescribe you the pill mostly. Anyway, that is what I have heard and also deriving from my own experience too. Even if I told the doctor that I do not want to use the pill, he/she would say, you have to use it. GPs think it is the best solution to the problem, although think of course the specific medicines which are not the pill, that work as well. But doctors prefer and they have their reason for prescribing the pill".

On the whole the pill is highly promoted and people have been mobilized systematically to adopt a very positive attitude towards the pill. It has been popularized by both the GPs and pharmaceutical companies. Parents and adolescents have come to appreciate it as both a medicine and birth control devise. The issues of side effects did not come up as a hindrance to the use of the pills. Adolescents believed that if one pill is not good for you, the GP would change for you, till you find one that suits your body. This improvement in attitudes and perceptions of adolescents towards the pill has had could be one of the pivotal factors in the reduction of teenage pregnancies in the Netherlands.

Communication about Safe Sex in Adolescents' Sexual Relationships

Study findings suggest that there is quite good communication among adolescents in relationships about issues of safe sex. Most of the adolescents noted that it is a difficult
thing to do but they felt strongly motivated to do it because of the phobia they have internalized of the consequences of unprotected sexual encounters. They observed that is hard to get started talking about the condom but once you begin to talk about it, all your fears become demystified.

For example, I had the following dialogue with an adolescent girl; Roos, a high school student, 18 years old.

Interviewer: What do you think of issues concerning communication about protected sex between boys and girls who are falling in love?

Roos: "Me myself I found it difficult to start talking about it. But it had to be talked about. I think that think it is not smart. You have to think about the future. You have to go to school, know yourself. I wanted to take the pill before any sexual intercourse began because I didn't want any accidents that could lead me to become pregnant. I had to go to my family doctor. I wasn't ready for it and he wasn't too. So we did it when we were ready for it and when all the preparation was taken care of.

Interviewer: How did you introduce this very delicate topic?

Roos: "Well, I introduced it, he did not start talking about it. I said, I think something need to be arranged (a lot of laughter), I said if you take care of your business, I will take care of my business. And he said, that is a very good idea. It becomes easier to talk about it, in the beginning it was very hard. In the beginning there was a financial problem because I had to pay for the pills myself. But my mother pays for it now".

I continued the discussion by asking her about other adolescents:

Interviewer: Do you think some people here do not have protected sex?

Roos: "Oh yes! I think it could be that they are very drunk or they have been taking drugs or because they do not dare to talk about it in a relationship. They find it difficult to talk about it because it is like a taboo. They are not accustomed to talking about it. When you started to talk about it once, it is easier to talk about it again. But for me I find it difficult to talk about it but I have no choice. But other people who find it too difficult, it is like climbing a wall. But I have never had about any accidents, so people must do something. They may be using the pill. It is easier to talk about the pill than the condom because the pill can also be used as a medicine for your belly pain when you have menstruation.

Interviewer: Do you have any of your friends whom you think have a big problem communicating?"
Roos:
“Well I know one boy and a girl who doesn’t use a condom. They say they do not want it but I think, they are afraid to talk about it. But for the rest everybody I know does double Dutch. Most of my friends are sensible enough to talk about it”.

Interviewer: Normally who takes the initiative to talk about it?

Roos
“I never asked any one but my impression, is the girl. Because the girls have the biggest problem if anything goes wrong. Girls are more conscious. But you also see in normal life that boys are more reckless. They often do more stupid and dangerous things than the girls. Whether it is something to do with cars, sports or anything. I think girls are more a little bit more careful. I think that this also translates itself to being careful in dealing with sexual issues. I think that boys careless. But maybe I should avoid this over generalization”.

She continued by making a strong argument about how the problem of communication among adolescent couples about protected sex should be addressed:

“If you want to prevent unwanted pregnancies and STDs, it is very important that you give education on sexual topics. The most important lesson to give with it is talk about it. You do not have to talk about it with every one but with everyone you are gonna have sex with. I think maybe that should also have been in my biology book that the most important lesson to learnt is talk about it. Sometimes teachers forget to emphasize it”.

For Roos and many other adolescents, the issue of communication about sex and protected sex in particular with your boyfriend is an uphill task. But they considered it a life and death matter. They rationalized about it and made it a point to introduce it to their boyfriends. Faced with what they perceive as a threat to their life, they buried their fears and confronted their boyfriends about the issue of safe sex. In other words, their subjectivity was overshadowed by rationality about the consequences of indulging in unprotected sex.

The other salient issue is that since the pill has assumed multiple functions and because most of the social barrier to using it have been off-saddled, most of the adolescents may be using the pill. This makes it almost impossible to be impregnated.

Further more, in a quite strong stance, a number of adolescents interviewed stated that if it is their first contact with a certain man, they made sure that they use what was called by Rademarkers “Double Dutch”; they are normally on the pill but in addition to this they insist on using the condom. They do this till they gain confidence that their partner is safe in terms of diseases or that he is not involved in multiple relationships:
For instance, a girl 20 years old, a high school student is quoted to have stated that:
"I personally wanted to know my boyfriend really well. To say okay we are becoming intimate together. So we discussed the thing well before we had sex. So I told him from the time bluntly that it was almost logical to have protection and to use protection. If you want to be intimate with me, he had no choice so he could go out and have sex with somebody else. He tried to push me to have sex without a condom or to do it without but... If he cannot respect me for my choices then he is not worthy being with him. I felt so insecure about it but anyway that time I did not know what sex was all about. I did not know what I was missing. I could talk so loud. I did not look forward to it. I placed them some distance. So I said well, if you do not respect my wishes, I do not like you at all. This may only come years and years in future if I can trust you. I said look, I don't know your past".

In the same manner, A first year university student, 19 years old is quoted to have made the following remark:

“No it always goes naturally. It never came to my mind not to use a condom for the 1st time. When I want to have sex with a boyfriend for the 1st time, I carry condoms myself and my boyfriend brings them along too. Here it is something routine, something very normal, where there is having sex, there is a condom to be used”.

In addition, it was acknowledged that the long you know each other before indulging in a serious sexual relationship or penetrative sex the better the communication about all aspects of your lives including protected sex. In this regard it was noted during course of executing the study that when young people are falling in love for each other for the first time, the time lag between the development of feelings for each other and indulging in penetrative sex is quite long. It was reported that it ranges between a minimum of three months, an average of six months and at most one year. This was acknowledged as a contributory factor to better communication of such adolescents about safe sexual practices. It was noted that during this time, they indulge in non-penetrative sexual activities ranging from kissing, caressing each other above and sometimes below their clothes and oral sexual practices. Study participants made several remarks about this issue. For example, an adolescent, a girl of 20 years old, made the following remark:

Interviewer: In a relationship, who takes the responsibility for safe sex?

“We both do, we just discussed it long before we did it (sex) for the first time. I was on pills and he took condoms with him and I think that was safe enough”.

Interviewer: At times communication about such things may be difficult, how did you handle it?

“It wasn’t scaring for us because we knew each other for long. It was a normal thing. May be it was quite scarcely to start a conversation on it but when you begin you just talk about it. If you do not want to get pregnant and when you are not sure whether he doesn’t have any other sexual relations, it makes a lot of sense to do it. You just must have that conversation before you get started”.

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In line with the above argument, one of the key informants, the research coordinator NISSO made the following submission:

“It seldom happens for adolescents here to begin with penetrative sex immediately, it goes quite slowly and then it goes further and further. They start with kissing or touching each other above the cloth and sometimes when they are a little bit further under the cloth. They can have masturbation, with their hands or with their mouth, but usually, there is three to four years between the first kiss the boy or girl has and the first time they have intercourse, not with the same partner but can be; they can switch partners. That is what I say to parents that they do not start with intercourse but start with other sorts of things. The mean age of intercourse is 17 years. And what we always say is; giving good sex education and being liberal about sexuality does not lead to earlier sexual behaviour. Other people think that when you talk to young children, teenagers about sexuality, you will make them to have sex. And that is not true. They will have sex anyway and when you do not talk about it, they do not know anything. They have not enough knowledge about contraception and if they start earlier they won’t escape the consequences”.

In other words, not indulging very early in penetrative sex may enable the adolescents in relationship to know each other better till they are ready or a serious sexual relationship. During this time, they may develop more positive values and a broader conception of sex as not merely for pleasure but for affection, respect of each other and treating each other with dignity. This better understanding of sexuality may lead to more communication about responsible sexual behaviour that may ultimately contribute to low levels of teenage pregnancy.

Another key informant, a researcher fellow gave more insight about the dynamics of sexual relationships among adolescents by aptly stating that:

“In general most teenagers make a link between love and sexuality, not marriage and sexuality, you should feel love and have affection for someone you have sex with. There are always exceptions to that rule. There are always people who want to have sex with everyone. But in general it is something within a relationship. And you see that teenagers in the Netherlands most of the time have some longer monogamous relationships but then after half a year or a year or two, it breaks up and then after a while they get a new relationship, this what we call serial monogamy. Always monogamous but they do switch partners after each other”.

It is probable that a high turn over of partners may hinder effective communication between the couples concerned with special regard to protected sex. Serial monogamy may provide a favorable environment for a culture of communication and negotiation about pertinent issues in sexual relationships such as safe sex.
In a similar situation, a female university student pointed out that in the beginning of relationships, both partners have the responsibility for contraception to avoid pregnancies and STDs. She hastened to add that, in the long run, it is the girl who continues with the pill because the boy may no longer have to use the condom. However, in the beginning the task is not strictly divided whereby, the boy brings condoms and the girl takes the pills. Both have to ensure that the condoms are there whenever they are going to have sex. She was quoted to have observed that:

“Well, now he does not have any responsibilities anymore. We both know that we haven’t got any diseases, so we do not use a condom as a form of protection anymore. And when we still did, it wasn’t his responsibility or mine, we just made sure that we always wear condoms and I always take my birth control pill. I brought condoms as he did, it was not divided kind of thing. And it never has been an issue of who is bringing what. We now both trust each other enough to not use any condoms and he knows I am taking my pills... not getting pregnant is a priority to me”.

In order to gain more insights about the communication among adolescents about protected sex, I had an in-depth interview with a boy of 19 years who is in his second year of high school. The key aspects of this interview are presented below:

Interviewer: Did you have protected sex?
Respondent: “I had condoms, and we used condoms, we use condoms through “.

Interviewer: How did you get introduced to the issue of condoms?
Respondent:

“She had a boyfriend before me. So she was a little more experienced than me. She brought the condom and said we are going to do it. I asked where are the condoms, and she had condoms, so we had it and used them. When she said we are going to do it, my first question was; where are the condoms. It is the most important thing because of AIDS. I really do not want to get AIDS”.

Interviewer: How did you feel while asking her for the condoms?
Respondent

“Well, on television we have commercials a boy and girl in bed having sex, well, you do not see it then they turn around and ask for a condom. You see a boy and a girl on a cushion and then they show a condom. So you see how to introduce the issue of condom in a love relationship on television”.

Interviewer : How did you feel about your first experience with both sex and the condom?
Respondent: “I did not feel weird about it. You just grow up with it and internalise it. When you have sex, you have a condom. No condom, no sex”.

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A focus group discussion with four adolescents: two boys and two girls helped to give more light about communication in adolescent sexual relationships. Key elements of it have been elucidated below:

Facilitator: What do you understand by safe sex?

Petier: “Generally it is sex with the use of condom. But you can combine it with the pill for actual safer sex against pregnancy”.

Bonifance: “I think it is efficient to use a condom. I never think that the condom is ineffective. The only thing you have to do is to take all the precautions. I mean what can you do about it. Lest you have to become a nun, and forget all about sex. Do not do sex anymore”.

Facilitator: Who takes the initiative for safe sex in relationship?

Petier: “They both do want it: If the boy doesn’t have condoms then sometimes it doesn’t go on”.

Anne: “I think that both want it, not that one of them... oh! here is a condom...oh! no, I don’t want it. I think both want it, and when there is no condom, it means no sex”.

Facilitator: Are there cases when a boy or girl doesn’t want to use a condom?

Anne: “Yea! It differs from person to person and what kind of education they have had and what their friends are doing”.

Bonifance: “It may arise in a situation where one of you is drunk”.

On the whole, the opinions of study participants above seem to suggest that a strong culture of communication about protected sex is developing among adolescents’ relationships in the Netherlands. It is backed up by the strong faith in the effectiveness of the contraceptive methods available especially the pill and the condom. There seems to be a strong drive and motivation for having protected sex among adolescents to avoid teenage pregnancies and STDs. The ability to communicate about sex is conceived as a major breakthrough towards facilitating adolescents to negotiate and to use safe sexual practices.

As already pointed out adolescents may have the knowledge and information but it is through purposeful communication that such knowledge begins to have a strong bearing on the sexual practices of those concerned. This motivation to communicate openly about safe sex in adolescent sexual relationships may be one of the vital factors contributing to the sharply declining levels of teenage pregnancy in the Netherlands. Of course such an achievement has not happened by accident. It may be a product of a positive socio-
cultural environment (openness and liberalism about sex) as well as service factors as discussed throughout this text.

Alcohol and safe sex among adolescents

Alcohol was in a number of cases cited as one of the problems that could render some adolescents unable to negotiate and maintain responsible sexual behaviour. For example, one of the adolescents, a girl of 20 years made the following observation:

“Many youth drink alcohol and it is accepted. If you are drunk, I assume you lose control. You could throw away some of your principles. I personally do not drink but I really see it that girls who go to drink are very easy to go with men or kiss. You may say I do not sleep with anyone but when you are drunk you may not seem to see things right. I think that if a girl does not persist on using a condom in situations like that then...it is different”.

Another adolescent, an 18-year old high school student made an observation that one may lose some of his/her principles if he/she is acting under the influence of drugs or alcohol:

“Oh yes!, there are people who may not have protected sex. I think it could be that they are very drunk or they have been taking drugs. Under such circumstances, they may be carried a way by their emotions”.

In line with the above arguments, during my visits to bars and discos in Amsterdam, after a couple of beers, I observed that the behaviour of some girls and their boyfriends changed quite considerably. In a visit to one of those dancing places, one of the couples seated next to me were indulging in sexually intimate actions like vigorous kissing and some fondling. Without a condom at hand, and if this couple would decide to indulge in sex they may run the risk of doing unprotected sex. But it gives a clue as to how alcohol may have a role in making young people behave in less sexually-responsible way.

It is worthy to note that this may be a danger as far as STDs are concerned but it may not be a great danger when it comes to pregnancy because adolescents would in most of the cases be using the pill and those who may have forgotten to take their can look for a morning after pill the following day. All adolescents interviewed who were sexually active reported to be using the pill. This could be due to their knowledge about sexuality, fertility and contraception.

Alcohol may thus “de-objectify” the actions of some adolescents rendering them unable to live to their expectations as far as safe sex is concerned. This could be one of the areas that the adolescent sexiologists could target while giving practically sound and informed sex education to adolescents.

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Perceptions of Adolescents towards Teenage Pregnancies

One's perception of what is and what ought to be plays a pivotal role in making decisions about his or her life. This perception is in turn shaped by many factors in an individual's social environment. Individuals therefore are largely a social construction.

Despite all the social influences that are significant in the making of an individual he remains a key actor in responding to socialized demands and tasks imposed on him by his/her social environment. These demands are highly dynamic especially at the adolescent stage. Teenage sexuality being one of the major challenges at this stage. Amidst such circumstances, the perception and actions taken by an adolescent to deal with the issue of sexuality will largely depend on one's skills, knowledge, confidence and vision that she/he brings into interaction with significant others in his or her social environment. These may thus shape their perceptions to many aspects of life including teenage pregnancy.

In line with the above proposition, it has been contended that girls in the west now start their menarche at an average age of twelve, and their fertility by thirteen or fourteen. This early sexual maturity is incompatible with their dependent status as children both at home and at school. Biologically a child becomes an adult earlier while socially a child becomes much later (Marcot 1980; cited in Cunningham 1984: 13).

Inspite of all these theoretical discussions, it is widely accepted that some adolescents cope better with sexuality while others fail to cope with it depending on some of the factors as already stipulated in this volume. In the Netherlands, for example, adolescents, according to the statistical data, have managed not only to postpone sex until an average age of 17 but have also been able to considerably avoid teenage pregnancy by using contraceptive methods. It was therefore one of the objectives of the study to explore the perceptions of these adolescents towards teenage pregnancies and to establish why they have such perceptions.

On the whole, study findings postulated that among the priorities of adolescents in the Netherlands, babies or pregnancy at an early age was ranked last. Their major priorities were good education, a satisfactory career and a very good job. There were nevertheless some adolescents who were ambivalent about teenage pregnancy but these were an exception to the rule.

However, even some of those who were ambivalent were only talking in terms of keeping a pregnancy if it came by accident but they would not deliberately plan to become pregnant while they were still adolescents. There were only two unique cases who said that in case all the facilities are in place; for instance, a steady and reliable boyfriend, a good job, parents who are willing to take care of the child such that you continue with education, they would not find it a problem to become pregnant because they like having children. But such cases were rare. But even then one could argue that these were being quite superficial. They set very high standards which may reflect their prejudices towards
teenage pregnancy. In other words, at their present state of affairs, which are the realities of their lives, they would not dare to become pregnant deliberately.

The major emphasis was on knowing yourself better and realizing most of your aspirations before you ever think of babies. This may also explain the reason why the age of marriage has risen in the Netherlands to an average of 28 years. However, to some adolescents, even marriage was not synonymous and/or directly linked to having babies. It was almost when one is at the “end of the road” that children were preferred. In this case end of the road does not mean old age but it means after knowing yourself and have a certain direction in your life.

Most of the study participants criticized teenagers who become pregnant as very stupid. Becoming pregnant at a young age was equated to robbing yourself of your life and crippling your social development opportunities. To a number of adolescents, it was perceived as unimaginable to become pregnant. They observed that in this individualistic and highly capitalistic society having children would mean a serious burden to an adolescent parent. Others observed that in case of it happening by accident, they would resort to abortion as an alternative. The ambivalent ones however, said they would think twice because abortion would be tantamount to killing a human being. It could be that these girls would immediately get a morning after pill in case having unprotected sex. Such perceptions may be a strong motivation for adolescents to effectively use the pills and condoms in order to avoid any accidents.

Both boys and girls had the same attitude but girls were more careful not to become pregnant. Of course this might be because they would carry most of the burden in case of a pregnancy and nurturing of the child.

In connection with issues raised above, Roos, an adolescent girl 18 years old made the following commentary:

“If one gets a baby, you cannot pay much attention to yourself. So you cannot learn and you lose part of your youth. If you want to get pregnant it should be between 24 - 30 years. If you have a baby, you can not go to a disco, you have to work so hard, you do not finish your studies”.

When I probed by specifically asking her, what is your opinion about girls who get pregnant at your age?

“Well first of all I think they should know for themselves. I think it is very stupid. If you are 18 and you want to be a mother, then you have to know for yourself if you really want that. I think you spoil your future because I think when you are 18, you want to go to a disco, you want to go out at night. And if you want to go out you have to hire someone to look after your child. And you can not go on holiday. If you want to go to University with a child, it becomes very difficult, I think you have to arrange lots of things. I think you should take a child when you are thirty or forty years, that is a good age to get a child.
Well but I can also understand; perhaps if you get pregnant by accident and you have a little baby in your belly, when it is growing in your belly, you may not want to kill it, you want to give it life. Then you will have a baby because you think it deserves a chance to live, I can understand that. If I got pregnant in this way, I don’t know what I would do because I still feel so young to have a baby”.

In a focus group discussion with boys, the boys made the following observations:

Interviewer: What do you think of a girl who becomes pregnant?

Jimmy: “I think that is being stupid, you should take care of yourself”.
Sam: “It is also stupid for a boy to make a girl of that age pregnant”.
Voulter: “I think at that age one should get an abortion”.

Interviewer: What would you do if you made a girl pregnant?

Rube: “I think you should talk about it with her, your family and her family. Then you can reach a decision”.
John: “If the parents can help you raise the child such that you can continue with your education, but if you can’t then you should have an abortion”.
Gerald: “I think that abortion is killing somebody, if your parents can raise it, it is better to keep it”.

In these opinions, these boys were seriously concerned about teenage pregnancy. They were so tensed and emotionally involved while discussing this issue. They were scared of impregnating a girl. And when asked about their reaction in case of impregnating the girl, they expressed a lot of difficulty as to how they would respond to such an issue. Their opinions indicate that they would start off a process of negotiation between their parents and those of the girl and some would chose the abortion option. All this indicates a negative attitude and perception towards teenage pregnancy.

In order to gain better insight in adolescent perceptions towards teenage pregnancy, I had an in-depth discussion with an adolescent girl, 20 years old, a first year university student.

Interviewer: How would you look at somebody who is a teenager and is pregnant here in the Netherlands?

“I have a friend who is married, she is now 25, I feel it was her choice and I respect that. When she had her first child, she was 17, she did not plan getting pregnant but she decided to keep it. She is a great mother and for her this was the right thing to do. But I also know somebody who had an abortion but I have never felt like she should have taken better care of herself. It was her choice, I am therefore not in position to judge either of them”
Interviewer: What of you yourself, How do you feel about it?

"My mother was 21 when she had me, and 18 when she had my sister. I think it is great that I have such a young mother and she raised us. She studied her education, got a good degree and now she has a good job. I think it is good that I have a young mother. And I regret the fact that if I ever be a mother, I won't be a young mother. I certainly know that there is a lot of incentives to being young, you have a lot of energy to put to your children. You are still very healthy and your body is capable to bear children. But I also feel that it is so constraining, you have no time for yourself to go out. You have a certain kind of stability to offer to your children."

Interviewer: What are your life priorities?

"My priorities now are to first get a good education, get a job. I do not see myself having children especially since my mother has given me such great childhood and I will always feel guilty if I cannot provide the same atmosphere for my children. And I do not see myself stopping to work and putting my career to a halt for a while to raise my children. I couldn't do that to my children. Since I had a great childhood. But maybe my opinion will change, since I am just twenty I can not be so sure. But becoming pregnant at a young age is not a priority to me. Maybe it is high in the US because having a child gives you access to social welfare. It is considered something positive in the US. Especially in the ghettos where, they feel having a child is some way of finding a man to your life. In the Netherlands, this does not happen that much."

In addition, an 18-year old girl studying in high school expressed ambivalence towards the notion of teenage pregnancy. She expressed a desire to have a baby but was also quick to express her hesitations.

"If I was pregnant now I would keep a child. But I wouldn't choose for it. I don't say: hey! I want to get pregnant now so I go to my boyfriend. I wouldn't do it on purpose. But if I become pregnant by accident then I would keep it. If I wasn't at school at this moment I would become pregnant. After my study I want as soon as possible to have a baby."

She continued by articulating her opinion about teenage pregnancy.

"Well if a girl from 18 or 19 years is pregnant, I wouldn't think that oh! You girl you are stupid or so and get an abortion but I do not think it is handy. It depends on what they are doing. If they have a home, a steady boyfriend or a job then it is okay. But if they are at school or have no job then it is not okay. But most important is that you are responsible enough to bring up a child and not under drugs or smoking."

For this girl the main issue was not age but the ability of the young couple to provide a conducive environment for their child. If the couple has the necessary facilities and were psycho-socially prepared to have a baby, then it is okay for them to go a head.
But it would be an over simplification to think that this the only thing she meant; she was hypothesizing of a world where young people have all the facilities and qualities of good motherhood at her age. For instance, having a sound educational qualifications, a decent place of their own to live, a steady boyfriend to mention but a few. Unfortunately, in reality there are quite few adolescents who may have all these favorable conditions at a young age.

Even for herself, she realized that she would have to postpone pregnancy till conditions are favorable. Thus her desires have been shaped by the reality that is prevailing in her social environment. This may be what most adolescents today need, to help them understand the dynamics of their life and provide practical information relevant to their circumstances.

In a similar note, another informant expressed some ambivalence towards the issue of teenage pregnancy. She expressed that pregnancy and motherhood is beautiful hastened to add that in order to give her children the best care, she had to wait for the right time. Thus her rationality was not overshadowed by her subjective feeling about pregnancy. She also brings in another dimension of the influence of her mother on the her perception of pregnancy. This is what she said:

"I would like to get pregnant but not now. Later I will have children but maybe when I am 25 or 26 years. First, I must get a life myself and then give it to my children. My mother always had a wonderful feeling about her pregnancy and wonderful ideas about it. So I must have it myself to know what she meant. She once told me, oh!, it is wonderful to be pregnant, it is a wonderful feeling so I must know what it feels and means but at the right time not now".

She continued by giving insight on the role of her parents in shaping her decision about teenage pregnancy. Her mum gives her a masked message which tells her the ideal age to have a baby. Her mother does not decide for her but positively motivates her to postpone pregnancy beyond the adolescent age.

"But I think I would choose in myself to have a baby now and my boyfriend would agree. Then she would say if you think it is okay, then go ahead. But she would be worried of the troubles. It would get since I have not yet finished my studies and I haven’t enough money. But if I have thought it over and be very certain about it, I think she would allow me. She would say, “if you think it is good, then I would help you. But I think she learnt me to be myself first. To find myself and to educate myself, find out what I am and then have children. It was underneath message I think because she tells me a lot, oh 26, it is a wonderful age to get children. So it serves as underneath message that earlier is not so smart.”

This girl went further to analyze the pros and cons of teenage pregnancy which may have largely played a role in shaping her perceptions towards pregnant teenagers. When I
asked her; What do you think about teenagers who become pregnant? She made the following remark:

"I think it is too early because they are themselves still children. They have not learnt to be on themselves and living on their own; haven't dealt with the world; managing their own things and their own life. I think, it wouldn't be very good if they raised a child while they are trying that out - the world. I think without trying out the world to see what fits better, it is not good to have a child with you."

She then changed sides to give an exposé of the advantages of having a child while you are still young enough. She said:

"But on the other side I think I could be a mother 20 or 21 and I have a child. But for a child if she is 15, you are still young. I think that if the parent is too old for the child, it may be a problem for it. Some times I think why haven't got a child now because then I could be a young mother and I should be very understanding may be when I am older, I would get angry sooner. I cannot understand why she is liking that kind of music. It is always ?, you have to get a good relationship with the child and I think if you are too old, that is hard. But may be I am not right I don't know, I have no".

It is imperative to note that this study participant displays the ambivalence in her arguments on one hand she feels that there are advantages for children to be raised by a young mother but on the other she feels that it is dangerous and unfortunate for minors to raise children because they are also children. This sets in motion a paradox in her mind which she fails to answer at the end when she says that "I do not know which is better because I have no experience".

It is in such a situation that some adolescents become trapped in a web of conflicting ideas. This may be called the "pregnancy trap". This is actually not a new phenomenon because at the stage of adolescence young people face what psychologists have called the "identity crisis". They are in a liminal stage with conflicting messages from their social environment and tumultuous biological changes in their physiology, emotions and hormonal secretions. It is at this stage that adolescents need the best information and motivation to enable them make informed decisions. This requires an "adolescent sensitive" approach and a careful communication of empathy and understanding of their paradoxes. This is when the significant others in their environment like the parents, peers, GPs have to play a role not as decision makers but as facilitators to enhance the positive coping capacities of the adolescents.

In the same vein, Reis as cited by Cunningham (1984:15) pointed out that,

"the adolescent is a marginal person who is no longer accorded the privileged status of the child, nor as yet many of the rights and responsibilities of an adult... The sexual behaviour of adolescents is primarily peer organized and peer controlled. As such it
reflects the attempt by adolescents to achieve a compromise between being encouraged to behave like adults and being denied the rights and privileges of that status”.

Similarly, Bernard cited by Cunningham (1984:15) observed that parental reactions may vary from outrage, shame, guilt to feelings of betrayal. “If only she had come to me and told”. Helping the child to be contraceptively prepared for possible or likely intercourse requires a realism on part of adults who may well feel that such help implies collusion with the girl, especially if she is under the age when her consent would be legal.

Notwithstanding the above argumentation, study findings as presented and discussed above tend to suggest quite a unique trend currently taking place in the Netherlands. What is shown above may have been an imperative issue during the sixties but it seems to have dramatically changed since then. In any case what authors like Bernard and Reis about adolescent sexuality said may largely apply to the non-indigenous groups. Data from both primary and secondary sources suggest that there have been major achievements in the Netherlands regarding responsible sexual behaviour in adolescents as well as in fostering positive interaction between adolescents and their significant others such as parents, peers, teachers and service providers.

To further illustrate this point, one of the key informants, a research coordinator in NISSO made the following analysis of teenage pregnancy in different groups of adolescents in the Netherlands. Like other scholars (Ketting, Doppenberg, Hardon and Scortino, Teitze and Hensual) who have written about adolescent reproductive issues in the Netherlands, she gives a unique and positive representation of typical Dutch adolescents:

“The pregnancy rates are higher in non indigenous Dutch groups than in the typical Dutch total population. And that has to do with cultural things. Being more ambivalent towards contraception because the meaning of having children can be different. To have a child can help you in keeping the husband, keeping the relationship, find more favour with the husband. But this does not work to keep a man monogamous because he can have other sexual relations. Thus being a mother can have a different meaning in respect to different cultural contexts”.

She went on to give an example of the socio-cultural situation in the Netherlands and how it influences the perceptions and decisions adolescents make about pregnancy:

“For example, in the Netherlands, most girls want to have a career or a good education. That is everywhere, you can see, where girls have more life opportunities, options, when they have a higher education or when they have more perspectives for a fulfilling job. Then they too want to become mothers but usually later. In the Netherlands, we have the highest age of a mother at the birth of the first child-28 years. And this has to do with the fact that people want to have a high education and work first for a couple of years and then they cannot combine that very easily with having a child because we do not live
close to our relatives most of the time. So when you have a child, you have to care for it. We do not have good child day care centres. It is just starting now.

In addition, she specifically makes a comparison between the Dutch girls and the Caribbean girls and how their different cultural settings make these two groups of girls to react differently when confronted with making choices about pregnancy.

In cultures where girls live more closely with relatives, then somebody can take care of their children. Your mother or sister can look after the child but here it is more individualistic and this makes it very difficult for a woman to choose for a child sometimes.

In conformity with Dr. Rademarkers remarks, another key informant, a research fellow in the area of adolescent reproductive health made the following observation about the differences in perceptions and socialization between the original Dutch and Caribbean girls regarding sexual and contraceptive behaviour:

“They dress more pornographically, they talk more jokes about sex. They have sex at an earlier age. They are having children also when they are young. Sometimes it is for status, something to have, to own. This especially if you look at the Bejilmer where you have young depressed girls. Then you hear stories that girls want to have babies because it would be almost the only thing they would feel is theirs. But this is something in the Dutch culture which is not at all at stake for the adolescents. You do not have to have children to be responsible. Being responsible for Dutch adolescents is viewed in terms of being able to finish your school or study and then find a good job”.

Some informants also point to the differences in the socialisation process between indigenous and non-indigenous Dutch families. They allude the fact that the manner of raising children can have an effect on future behaviours of such children, e.g., in decision making.

“I think that the upbringing of the children in Surinam families is quite loose and the mother has a very big impact. The Dutch are very rational, they learn, they teach, they talk, they compromise all the time with their children. Even if they are going for holiday, the children will be asked where they want to go. If there are differing views, they may even toss a coin. If you tell a Dutch child, the Dutch child will ask why and if you do not give it a good reason, then the child will think otherwise. So there is a lot of compromising, a lot of explaining, a lot of talking and responsibility. You are supposed to think before you do things. They are not like the Moroccans who think that people learn by doing or learning through experience”. (research fellow).

In the same vein, a mother of a 15-year old daughter who lives in Zandam near Amsterdam made a comparison between the Dutch girls and Surinam. She began, however by explaining how she has raised her daughter to be confident of herself while making her own decisions.
"My daughter is her own judge for her body and her sexuality. She can do whatever she wants. I think it is okay. I do not own her. I am a mother but it is not for me to decide to what she can or cannot do with her body. So that is my respect to her to make her own choice. I also believe that she is capable of making a right choice. That is why I can leave it to her and not worry or have the need to control her. What I do not want is her to make mistakes because she didn’t know. I want to make sure she knows everything so that she make her own choice but never the wrong choice”.

She systematically proceeded by articulating the differences Dutch girls and girls from other culture:

"People I know personally who got pregnant very young, 16-18 years old were most of the time people from another country like Surinam. Many Surinam people live in Holland because they are also Dutch actually. For some reason I found out that Surinam girls do not like to take the pill. They do not feel comfortable with swallowing pills and they also think that they are very fertile, so they can get pregnant very easily. So they combine high fertility and dislike for the pill. So maybe they have sexual contact once, when they are 16 years and they are right away pregnant. So I think that the amount of pregnancy is for a large part formed by that group and also people from lower social class, maybe because they do not talk about it in the family or maybe children do not know much and do not dare to ask for protection. For another part, I also think that people from Turkey and Morocco, I know from the papers that in those groups also women are young when they get pregnant. In that culture I think it is not normal to talk about it. They are only allowed to have sexual contact when they are married. Any free girl has to be a virgin when she gets married. But I think that is difficult too. I think that because it is so strict they want to get out of it and do their own way. I think maybe because I let my daughter to do what she wants; there is no need for her to do it under the pretext that she does not want to do what I her mother says. It is her choice, it does not matter whether she does it now or later. And may be when the parent says, I do not want you to do this, then the child, I do not know may do the opposite”.

A reflection of the foregoing arguments on the state of interaction between adolescents in the Netherlands and their parents, and significant others like media managers, peers and the GPs, seems to suggest a positive trend in terms providing an enabling environment that enhances the capacities of adolescents to make responsible decisions about their sexuality and prevention of teenage pregnancies. They are given the freedom but the responsibility that goes with this freedom is also emphasised. To minimize the likelihood of adolescents making mistakes, they are given adequate information from the relevant socialization agents to develop their problem solving capacities.

As already documented this has been achieved by a combination of openness and liberalism of purpose about sexuality on one hand and motivation to use contraceptive services on the other. It is therefore not a surprise that the Netherlands has been able to improve the perceptions of adolescents about pregnancy thereby scaling down the rate of
teenage pregnancy to levels, which has become a model for other countries that still have high rates of teenage pregnancies.
Chapter Five
Conclusion and Some Recommendations

As already elucidated in the study synopsis, the overall objective of this study was to establish the socio-cultural and service factors that could explain the low levels of teenage pregnancy (10 per 1000) in the Netherlands relative to other developed countries like Britain and Wales (69 per 1000), the United states (96 per 1000), and last but not least developing countries like Uganda with over 40% of the adolescents become pregnant at a young age.

It is imperative to note however, that given the small sample and short life span of the study, it would be unrealistic and simplistic to make generalizations based on the study findings. What I have done in this conclusion therefore is to give insight on the some of the salient issues that seemed to be plausibly contributing to the low levels of teenage pregnancy in the Netherlands. These issues may specifically apply to the sample that I selected for the study. A much bigger study will be required to make fair and informed generalizations.

It was established that the crux of the success of the Dutch story of teenage pregnancy is largely to do with the way the Dutch deal with sex and contraception. In fact, pregnancy was found not to the agenda of most adolescents that were part of the study. Rather it would be a better representation of the opinions of these adolescents to state that what was on their agenda was contraception. Pregnancy was maybe something that would only come up spontaneously in their mind but would not be seriously problematised as a major issue in their current lives.

The major issue was contraception and in particular the pill that fits one’s body best. In other words, pregnancy as a problem seemed to have achieved a marginal "status" among the Dutch adolescents that were interviewed. The issue that was of their interest to talk and cogitate about was contraception. This attitude was also reflected in the parent children interaction, peer interactions, adolescent-General Practitioner-interactions and adolescent media interactions. Thus as already mentioned, pregnancy per se was found to be in the addendum rather than the preface of adolescents and parents on one hand and service providers on the other.

There seems to be high acceptance of contraception among the youth in the Netherlands. The pill was very popular among adolescents. “Sexualization” of the pill had almost seized because it had become a multipurpose device for GPs and adolescents in the Netherlands. It was used both as a medicine and as a contraceptive tool. Routinization of the pill as one of the normal medicines and things an adolescent has to take is a unique phenomenon may have developed as a typical culture among Dutch adolescents. However, pill usage even seemed to raise to higher levels as adolescents grow older and engage in sex quite more frequently.
At the initial stages of a relationship adolescents tend to use both the pills and the condom ("Double Dutch") but when the relationships become stable, they tend to mostly use the pill. There are though some adolescents who reported to have persisted with both the pill and the condom even when they had steady partners. Adolescents also seem to have longer periods of courtship in the beginning before they engage penetrative sex but as they grow older they tend to shorten the time between courting and penetrative sexual intercourse.

Study findings suggest that condoms are popular among adolescents, but they cannot be equated to the popularity of the pill. Condoms are perceived by both boys and girls to be efficient in protection against STDs and pregnancy. But they mostly stressed their importance in terms of prevention of STDs and the pill for prevention of pregnancy. Some girls equated their boyfriend’s using condoms as a form of respect to them. The price of condoms is perceived as high by younger adolescent boys (15-17) while the older adolescent boys felt that the price was not as high as to inhibit them from using the condoms. This may be due to the fact that older adolescents could have better income sources than the young ones who may mostly rely on their parents. The insurance only pays for the pill but the condoms are completely a responsibility of the users to buy. This was perceived by the younger boys as negative discrimination of their needs.

There is relativity in the openness of parents to their children. Openness of parents ranged on a continuum. There were those parents who were very open, those are moderately open and those who are almost not open to discuss sexual issues. Communication of parents with their children about sexuality was characterized by talking about tools to foster safe sex for adolescents rather than making jokes about it. If there were any jokes, they were perceived as strategic jokes which would lead to a discussion on the tools to enhance the capacity of adolescents to make responsible decisions about sex. This is what I prefer to call “openness and liberalism of purpose”.

Thus, contrary to many other countries, study findings unraveled that Dutch’s attitude towards teenage sexuality is not a moralistic one but a pragmatic one. This is similar to what Dr. Rademarkers (1996:1) called “restrictive permissively”. It means that parents and other adults generally accept the fact that most adolescents are interested in sex and that they are sexually active. They do not encourage it, often they even feel ambivalent about it, but they do not condemn it. Sexual experimenting is therefore considered an inevitable and normal step in adolescent development.

However, it was established that parents are more comfortable to answer questions but the children are less comfortable to pose sexually intimate questions to their parents. This suggests that communication is partly open especially in discussing contraceptive techniques. This however, did not apply to all the interactions between parents and children, it was relative from one family to another. Some parents managed to provide an environment which redeemed their children of fears to discuss with them sexually sensitive questions, if not all, at least questions that are instrumental in empowering an adolescent to deal better with some of his/her sexual paradoxes. This is why I argue
strongly that openness about sexuality in interactions between parents and children was established to be taking place along a continuum, ranging from very open interactions through mildly open interactions to just fairly open interactions.

It was not possible to make an objective generalization on the characteristics of parents who are almost not open and those who are open because most adolescents interviewed seemed to come from similar social status families and the parents too were more or less of the same social class. Not enough information was collected to enable the researcher to make informed comments about this issue. What was noted however, is that even among parents from more or less the same social class, there seemed to be differences in the extent to which they and their children communicate about sexuality and contraception. Some parents ended at a theoretical level while others derived deeper into the emotional and intimate values of sex. Some adolescents were more open to their parents than others. However, despite the differences in openness, its sole purpose was to enable adolescents make better decisions about their sexuality and thus avoid unplanned pregnancies and STDs. Another study will be needed to establish the role of social class in influencing openness of interactions between parents and children regarding communication about sex.

It was further established that parent-children communication about sex or sex education occurs spontaneously. It is very informal and/or non-structured and stems from normal family life events such as conversations, TV shows, questions to mention but only three.

The study also unraveled that there is no "genderized" division of tasks of sexual education. Either of the parents can communicate to the children about their sex related questions. The most important thing to the adolescent is convenience viewed in terms of which parent is easier to talk to. In some cases availability and accessibility of the parent is also cited as an important determinant of parent an adolescent talked to. Overall however it was noted that there is no division of sex education according to gender.

Peer interaction and communication about sexuality among adolescents is primarily motivated by the need to share experiences and to give emotional and psychological support to each other in case of issues that may arise during the interaction between adolescent boys and girls. Peers are perceived by adolescents as a good avenue for sharing and learning new experiences about sex. It is therefore plausible that given the fact that there is quite a good range of technically designated sources of information, discussion with peers largely focus on social and emotional dimension of adolescent sexuality. It is when adolescents who did not have good communication with their parents about sexuality that peers are ranked as helpful for both technical and emotional reasons.

This findings is in consonance with the argument by Moore, Peterson and Furstenberg (1986) in Miller et al (1992:2) that:

"the social influences upon sexual behaviour are many but the family and peers are the primary agents". 
While that was the case with peers, study findings suggest that the school is very instrumental in giving sex education to adolescents especially from a technical point of view. It was the perception of study participants that the school starts sex education late and its approach is largely theoretical and examination oriented. Nevertheless, the school should be recognized as a vital sexual socialization agent because this technical information though devoid of the practical experiences of adolescents can help adolescents to know what to do.

What receives inadequate attention from the school is how to do translate the technical know-how into practice. This leaves a gap which needs to be filled. This is when partnership between parents and teachers and the media becomes imperative in the delivery of adolescent reproductive health services.

Using the principle of “comparative advantage” developed by economists, each of these parties (agents) can handle what it does best. This may result into synergetic effects of cooperation. This would largely stem from the fact that the strength of each of these socialization agents may be optimized while the shortcomings could be minimized. This would in effect foster an organized socialized attack on the problems of adolescent sexual insecurity. An in-depth analysis of the Netherlands situation suggests that the various key social institutions (parents, schools, media and social and health service providers and the state) are working together to fight the problem of teenage pregnancy.

It was also established that there seems to be no formally constructed peer organizations in whose primary role is to foster safe sexual practices among adolescents. There wasn’t anything to do with peer sex educators in the schools. This is an area that could, if well researched, be exploited to supplement the sex education provided by biology teachers in the schools. This suggestion is in line with the argumentation by WHO (1994:6) that peer reinforcement and support for health actions is crucial, as peer norms are powerful motivations of young people’s behaviour. In addition, it is argued that programs which use peer leaders are effective because peers are likely to be more familiar with youth language and culture.

The media is a very vital institution in the socialization of adolescent in social aspects such as sexuality. It was applauded for its wide coverage, simplicity, frankness and explicitness and coordination in delivering sexual information to the youth.

The youth magazines and the television are ranked very highly by the study participants as instrumental in the disseminating both practical and technical information adjusted to the simple language that adolescents can easily comprehend. Teenage magazines seemed to be more popular among younger adolescents (12-16 years old). Compared to certain movies aired on TV, adolescents felt that experiences of girls in the magazines are easy to identify with and are very anonymous. Older adolescents explicitly observed that magazines were no longer so useful to them as away a source sex education. The educational value of certain youth magazines becomes lesser and lesser as adolescents
grow and start having real experiences of sexuality. They start criticising some of their stories (for example the story that appeared in the YES magazine where a girl was masturbating with a sausage and it got stuck in her vagina). Whereas such story could be appealing to the young group of adolescents, it may not be so appealing to the older groups.

The role of the church in shaping adolescent sexuality has sharply declined especially in the urban enclaves of the Netherlands. Most parents and adolescents interviewed contended that they do not think the church has had any influence on their sexual behaviour. Participants do not think that having sexual behaviour before marriage is a sin, nor do they believe in that there is hell waiting for those who are have pre-marital sex. The church may therefore not be counted among the significant socialization agents in the Netherlands in respect to sexuality, contraception and teenage pregnancy.

The quality of adolescent reproductive services was perceived to be high by all the study participants. On the whole, service providers were described to be non prejudicial and highly motivated to promote responsible sexual behaviour. At the centre of these services is the GP. S/he is responsible for making prescriptions of pills to adolescents. Confidentiality was reported to be high. The services were both available and accessible. It was however noted that the prices for consultation are on the rise because the government is withdrawing most of its subsidies from many social sectors including adolescent reproductive services. The Rutgerstichting has been one of the organizations that have been quite seriously hit by the withdrawal of government subsidies. Overall, the quality of services is high and is highly regarded by the adolescents and other relevant groups.

Alcohol drinking was perceived by respondents to negatively affect sexual behaviour of adolescents. They became vulnerable to either forgetting the pill or not being strict about using condoms. Most emphasis was put on failing to adhere to one’s rational principles because he/she is under the influence of alcohol. Alcohol drinking is considered more dangerous from the point of view of contracting STDs than getting pregnant. This is because the girl may have taken the pill or even if she forgot one under the influence of alcohol, it is possible and she could be aware that she can use the morning pill to counteract the effects of the unprotected sex.

Teenage pregnancy is perceived by adolescents as something not preferred at their age. Their priorities were described in terms of having a good education, good job and career in life. Pregnancy was only preferred after such had been accomplished. In the immediate plans of most adolescents, pregnancy did not surface as one of the major items on their agenda. Their perceptions towards pregnancy at a young age are on the whole negative and most informants had a low opinion of the girls that become pregnant at a young age. They would respect their decisions but would also describe these girls as stupid and naive. There are some adolescents who seemed to be ambivalent about teenage pregnancy but even with these, the bottom-line was that they can only afford to become pregnant after their school career.
Communication in the interactions between adolescents in relationships about protected sex was noted to be relative from one couple to another. It was however, established that the longer the relationship the better the communication among the couples. With a long period between courtship and penetrative sex, adolescents reported that there would be enough opportunities for the couple who intend to have penetrative sex to communicate and make the necessary preparations for safe sex. This is also relative but it ranges from the pill only, to using both the pill and the condom. As earlier stated it may also begin with the both the pill and the condom but when the relationship becomes stable they may just use only the pill.

In a nutshell, the low levels of teenage pregnancy in the Netherlands can not be attributed to a single factor. There are several factors that have worked in partnership, reinforcing each other to produce the positive adolescent reproductive situation that is thriving today in the Netherlands. These range from historical, socio-cultural and well quality service factors that have combined in various magnitudes to incrementally contribute to this positive social phenomenon. The most outstanding feature however is the Dutch’s pragmatic approach which deliberately seeks practical solutions. This is reflected in the openness and liberalism of purpose as well as in the establishment of well organized health system that is able to respond to the reproductive needs of adolescents.
Appendix

Interview Guide
1. What are the different sources of information about sexuality available and accessible to adolescents in their neighbourhood?
   - Parents, teachers, peers, magazines, health educators (General Practitioners) extra.

2. What kinds of sexual education messages (information) are received by adolescents from the identified information sources?
   - Do adolescents actively ask questions on sexual related issues? To whom do they ask and/or discuss sexual related matters?

3. What are the opinions of adolescents about the messages received from the above information agencies or agents?
   - What are the perceived differences in information adolescents receive from the different sources mentioned?
   - Are there differences in the types of information received from parents and peers?
   - Are there differences in sex education messages given by General Practitioners and School Teachers?

4. At what age do parents start to give sex education information to their children?
   - Is there a difference in the age at which parents start and/or intensify giving sex education for girls and boys?
   - What are the perceived differences between messages given by the fathers and those given by mothers to adolescent boys and girls?

5. How do adolescents both boys and girls rate the information given by fathers and that given by mothers in terms of both content and ‘impact’?
   - To what details do parents go regarding sexual education messages to their adolescent children?
   - What information do adolescents expect from their parents?
To what extent is (was) the information they receive (received) in consonance with their expectations?

6. What are the perceived strengths and limitations of the GPs, Teachers and Peers sexual education agents or agencies in giving sexual education to them?

- What are the perceptions/opinions of adolescents towards sex education by or from general practitioners?

- To what details do General practitioners go in terms sex education messages to adolescents?

- At what age do GPs begin giving sex education to adolescents?

- What is the perceived content and quality of sex education messages by School Teachers?

- What is the adolescents’ assessment of information received from peers?

- To what extent are the sexual messages received from GPs and/or Teachers in cognizance with the adolescents’ expectations of the information to be received from these agents?

7. What are the different types of magazines that convey sexual messages to the adolescents?

- What is the adolescents’ perception of the content and quality of sexual messages given by the different types of magazines vis-à-vis their expectations and information needs?

- What are the perceived limitations and strengths of magazines vis-à-vis other sex education agents?

- How do adolescents rate sexual related information communicated through other media channels such as the television and radio?

- Do they rate different television and radio stations differently?

- What explanations are given for the different preferences and ratings?

- What is perceived to be the role of the church in nurturing and influencing the sexual and reproductive behaviour of adolescents?
8. How and when do adolescent sexual relationships begin?
   • What is the time lag between courting and penetrative sexual relations?
   • Who takes the initiative to begin a ‘serious’ sexual relationship?
   • What do adolescents perceive to be risky sexual behaviour?
   • What influences the ways in which adolescents perceive their sexual behaviour?
   • To what do adolescents attribute their control of sexual related behaviour?

9. What are the perceptions of adolescents towards teenage pregnancy?
   • What ambivalence exists in the adolescent perceptions of teenage pregnancies?
   • Are there any positive perceptions towards teenage pregnancies among adolescents? If yes, why? And if no, why?

10. What are the perceived responsibilities of each partner in a relationship?
    • Who of the partners takes the initiative for protection against teenage pregnancies and other associated risks? If it is the girl, why? And if it is the boy, why?

11. With whom do adolescents share information about their sexual relationships, contraception and pregnancy? and why do they have a preference for that agent?

12. Is there anything special in the upbringing of adolescents in the Netherlands that they feel could be motivating or facilitating them to have autonomy and control over their sexuality?

13. What are the perceptions of adolescents towards reproductive health services (quality of care; strengths and limitations?)
    • Are they accessible, affordable confidential, convenient and non-prejudicial?
    • What gaps exist in the reproductive health services from the point of view of the adolescents?

14. What suggestions do adolescents have about the reproductive health situation (teenage pregnancies and STDs) in the Netherlands?

Guide for In-depth Interviews with Parents
• Do adolescents actively ask questions on sexual related issues? To whom do they ask and/or discuss sexual related matters?

• What are kinds of sex education messages do parents communicate to their adolescent children? How are these messages communicated?

• At what age do parents start to give sex education information to their children?

• Is there a difference in the age at which parents start and/or intensify giving sex education for girls and boys?

• What are the perceived differences between messages given by the fathers and those given by mothers to adolescent boys and girls?

• To what details do parents go regarding sexual education messages to their adolescent children? What local terms and/or metaphors do parents apply while talking to their children about sex?

• How do parents describe the interaction their adolescent children while discussing sexual related matters? What reactions and feelings are involved?

• What types of questions do the adolescents ask their parents?

• To what are the sexual information needs of the adolescents from the parents point of view?

• What challenges do parents experience in their attempt to provide sex education to their children? How do the parents try to cope with these challenges?

• What are the perceived strengths and limitations of the other sex education agents (GPs, Teachers and Peers, church) in giving sexual education to them from the point of view of the parents?

NB: The list of topics (research themes) above were rephrased while interviewing key informants (teachers, reproductive health workers and researchers). They were rephrased depending on the characteristics of the informant being interviewed. Even for the case of adolescents, the researcher will attempt to be flexible and to start with less sensitive questions and personal questions before proceeding to opinion types of questions. This is intended at rapport creation. It could also reduce the possibility of getting biased/influenced responses to the relevant research themes in the topic list.
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PROBLEM ANALYSIS DIAGRAM
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POLICY AND LEGAL ISSUES

SOCIO-ECONOMIC SITUATION OF ADOLESCENTS
- BARGAINING POWER
- GENDER ISSUES

GOOD AVAILABILITY OF AND ACCESSIBILITY TO CONTRACEPTIVES

GOOD SOCIALIZATION
- GOOD SEX EDUCATION
- CLEAR CONCEPT OF SEXUALITY
- INDIVIDUAL RESPONSIBILITY

LOW TEENAGE PREGNANCY

SAFE SEXUAL BEHAVIOUR OF ADOLESCENTS

GOOD COMMUNICATION AMONG ADOLESCENTS ABOUT SEXUALITY
- GOOD RELATIONSHIPS BETWEEN ADOLESCENTS AND SOCIALIZATION AGENTS
(GPs, peers, church, teachers, parents, media)

ADOLESCENTS PERCEPTION OF TEENAGE PREGNANCY