Adolescent Pregnancy in Switzerland

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Keywords

Switzerland: Abortions · Adolescent birth rate · Adolescent pregnancy · Cultural values · Migration status · Pre- and postnatal care · Religious affiliation · Sex education

Introduction

Germany, France, Italy, and Austria surround Switzerland, which is located in the middle of Western European. We have a population of approximately 8 million people living in 26 provinces (cantons). Switzerland is multicultural and multilingual, with four official languages. Although the Alps cover the greater part of the country, there are thriving urban areas and cities and a large rural area. The Swiss Confederation established 1291 was a defensive alliance between three cantons. This confederation evolved to a fully fledged federal state of 26 cantons. The constitution of 1848 established the centralized government that exists today. Over the centuries, Switzerland's neutrality, has for the most part, been respected and is well known worldwide. During the last half of the twentieth century, as the political and economic integration of Europe has moved forward, Switzerland's has taken a corresponding path. Switzerland is not a member of the European Union (EU) but participates in the EU single-market system. The Swiss people rejected membership in the EU in 2001. Yet, the country has close ties with the EU established through a series of bilateral treaties. In these treaties, the Swiss government adopted provisions of the EU law. By adopting the provisions in these bilateral agreements, the Swiss are allowed to participate in the EU's single-market system and still maintain their sovereignty. Although today, Switzerland is less insulated from other European countries and more involved in projects sponsored by the United Nations and other international organizations around the world, Switzerland maintains its long-held conviction of sovereignty and neutrality (Foulkes 2012; swissworld.org 2012).

Adolescent Pregnancy

Currently, the number of live births in Switzerland before the age of 20 is approximately 4 per 1,000 adolescent girls aged 15–19. This is the lowest prevalence of adolescent pregnancy in

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Europe along with the Netherlands, which is also 4 per 1,000 live births among adolescent girls (Bajos et al. 2004; World Bank 2011). In other European countries, rates of live births range from 10 to 20 per 1,000 adolescents females. In the United Kingdom, the rate of live births is around 30 per 1,000, and in some Eastern European countries, the rate is 60 per 1,000 adolescent girls.

In Switzerland, starting in about 1970, the adolescent birth rate among 15–19-year-old girls began to decline. It declined from a high rate of 16 live births per 1,000 to 5 births per 1,000 by 2000 to 4 per 1,000 by 2007. The rate has remained stable at 4 per 1,000 since. The influence of major social changes like sexual liberation, increase of the adolescent population, and women empowerment during these years may partly explain this decline. Cultural changes such as independence, education, and professional activity available for young women may have resulted in older mean age at marriage and childbearing.

Adolescent pregnancy is not necessarily perceived negatively within the Swiss society. Often, parents accept their daughter's pregnancy and the fact that she will stay at home. In school, the pregnant girl is not categorically rejected. Social and school health services are available to negotiate special arrangement for school attendance. Public assistance exists for child day care and is accessible for adolescent mothers.

Swiss Abortions are Safe, Legal, and Rare

Swiss adolescents have one of the lowest birth and abortion rate in the world. A rate that can be described as, "safe, legal, and rare". Access to contraception plays a major role in reducing the rate of adolescent pregnancy in Switzerland. Switzerland pioneered contraception and family planning centers in Europe. In cantons where Protestantism was regarded as the principle religion, sex education and contraception were available in most clinics.

Oral contraceptives in Switzerland have been on the market since the early 1960s, and condom use has been promoted through the national campaigns for AIDS prevention since the 1980s. Additionally, when young women and girls become sexually active, it is standard practice for them to visit a gynecologist to determine the best contraception. Subsequently, most youth (75 % among 16–20 year old) use at least a condom during first intercourse and the vast majority of youth (87 %) use oral and/or condom) contraception (Narring et al. 2000).

The first HIV prevention campaign in 1985 and all subsequent preventive efforts resulted in effective promotion of condom use in the general population and especially among youths (Dubois-Arber et al. 1989; Gutzwiller et al. 1998; Narring et al. 2000). In 2011, the objectives of preventive campaigns were enlarged to include not only HIV but also other sexually transmitted infections (STIs). The strategy included availability of high-quality condoms, mass media "love life stop aids" campaign, sex education in schools, and individual counseling.

Avoiding pregnancy through using effective contraceptives at sexual intercourse is the preferred preventive method, but in case of contraceptive failure (lack of contraception, condom failure, or disruption in oral contraception), emergency contraception (also called "postcoital contraception" or "morning-after pill") has been used for about 20 years in Switzerland and other European countries.

Swiss law changed in 2002 to allow abortion on request within the first 12 weeks of pregnancy. Progestogens were also introduced in 2002 in Switzerland as emergency contraception and are available over the counter for adolescents older than 16 years. Pharmacists were trained in consulting women, and every pharmacy has a confidential space where initial evaluation takes place. Emergency contraception is also given in gynecological emergency services in hospitals, family planning clinics, and by gynecologists and general practitioners in private practice. Since then, the abortion rate has gradually fallen and stabilized (Ottesen et al. 2002).

In Switzerland, family planning services are widely accessible and frequently visited by adolescents and youths. Family planning consultation is free of charge. EC costs about US$7 per dose of single use (2011) and may be prescribed to young girls younger than 18 years without parental consent. Although there is not a strict age for decision-making capacity in Switzerland, a variety of clinical decisions or treatments are permitted if the decision-making capacity is confirmed by a medical professional, which in practice is usually given to females between 13 and 14 years.

Despite a restrictive federal law on abortion, dating back to 1942, the possibility to terminate a pregnancy is offered in almost all cantons. Required by this law, abortion was authorized if the pregnancy was a life-threatening danger, or a danger that could seriously harm the health of the mother. Two medical professionals must attest to the level of potential harm to the mother before abortion services are provided. The most liberal provincial authorities had established practical regulations, making abortion accessible to women for more than 40 years. In 2002, Swiss citizens voted in favor of new laws that legalized the termination of pregnancy up to 12 weeks of amenorrhea. As of 2012, some 22 other European countries have enacted new abortion laws (Boland and Katzive 2008).

The laws on abortion do specify a minimum age. Girls younger than 16 years, seeking an abortion, are required to go to specialized centers for younger girls where they receive age-appropriate counseling based on their age and development stage. The team in that center determines if the adolescent has the decision-making capacity to decide on abortion. In general, girls under 16 are encouraged to inform one of their parents or another adult. Ninety percent of the costs of the procedure are paid by medical insurance.

The abortion rate has remained stable in Switzerland at 6.4 per 1,000 women of childbearing age (Office fédéral de la statistique 2011). The abortion rate for adolescent females aged 15–19 is 4.0 per 1,000.

Birth Rate and Determinants Associated with Adolescent Motherhood

The adolescent birth rate has also decreased in the last 20 years. A study conducted by the federal office of Statistics has underlined level of education, nationality, and cultural backgrounds as associated parameters to adolescent deliveries (Wanner 2005).

The proportion of unmarried adolescents has dramatically increased. The father is usually older than the mother (mean difference + 7.7 years) (Wanner). This observation has not changed since 1969. Level of education seems to be one of the variables showing a strong association with adolescent deliveries. Adolescent mothers have a lower level of education than their counterparts of the same age, demonstrating the difficulties passing to a higher level of education or achieving a better level of training with a child.

Studies in the United Stated and the United Kingdom demonstrate that a higher proportion of adolescents pregnancies occurring with ethnic minorities (Berthoud and Robson 2000; Ventura et al. 2001). In Switzerland, the adolescent delivery rate is also higher among non-Swiss compared with Swiss women (Women from non-UE/AELE nationality exhibit the highest rates). Over the last decades, a higher adolescent delivery rate has originated from the successive waves of migration from Spain, Portugal, Yugoslavia, Africa, and Central and South America.

Studies in Switzerland suggest that migration status, religious affiliation, and cultural values are important determinants (Fontana and Bernand 1995). Migrant status and culture might account for less access to contraception and reproductive health services. Cultural values and religious affiliation might attenuate sexual education or reduce acceptance of abortion.

Medical Issues

Pragmatic approaches to sexual health of the adolescent, with improved access to confidential contraceptive services, are considered to be the main determinant in the decline in adolescent pregnancy rate in occidental and Northern European countries (Singh and Darroch 2000). The different causal factors related to adolescent pregnancy are precocious sexual relationship, absence of contraception, pregnancy in adolescents, a lack of adolescent friendly services, and availability of health services, socioeconomic conditions, cultural and social context, and the predilections of each individual adolescent (Fullerton 1997).

Pre- and Postnatal Care

Access to contraception and pregnancy tests are crucial for adolescent girls. Counseling in sexual and reproductive health and behavioral issues increases the quality of care related to adolescent pregnancy. Access to health care is relatively high for adolescents and young women in Switzerland because the country has a private insurance system with universal coverage. In a national school-based survey, more than 75 % of young females visited a doctor during the last 12 months. In this health care system, high-risk and low-SES individuals can access general practitioners to the same extent as less vulnerable young people (Haller et al. 2008).

Pregnant adolescent girls benefit, in most cities of the country, from a structured prenatal follow-up visits, conducted by midwives or physicians, and if they are near large university hospitals, by a multidisciplinary team, which addresses not only the somatic aspects of the pregnancy but also the patient's psychosocial well-being. Patients are entitled to "private" sessions with physicians who specialize in adolescent care. When appropriate, the partner and other members of the extended family are involved directly in the care. From about 20-week gestation, midwives begin the preparation for the delivery and newborn care. Patients and partners participate in a structured individualized course, which prepares them for the actual birth and instructs the parent(s) on the best way to care for a newborn.

Young parents are encouraged to join a support groups for young mothers and young parents. They are encouraged to meet with others in the support group before and after the delivery. As well, services provided by the midwives, trained nurses, and psychologists are available as needed. In these groups, meeting advice is sought and support is offered. These groups work closely with hospitals and provide not only emotional support but also medical attention when required (pelvic floor relaxation, urinary stress incontinence, breast-feeding complications, etc.)

Continued follow-up with the multidisciplinary adolescent medical team is based on the need of the parent(s) and the child. The network includes the doctor and the nurse who can help with other medical, psychological and social needs, in an organized link with social services and the family, or foster home.

Poverty, Family Supports, and Structure

Childbirth before the age of 20 seems to be associated with single-parent family later (Wanner 2005). When asked, most adolescent mothers consider taking care of their child while working in a fulltime job. Even so, the response remains allusive because a higher percentage of young females who express this view are unskilled workers, which suggests fewer work opportunities available to them after delivery (Narring et al. 1996).

Legal Issues

Swiss law supports the right of a child to know who his or her father is. A woman of any age who does not give the name of the father on the birth certificate will loose her parental authority

over the child until an investigation is carried out. A man who fathers a child has the obligation of responsibility for some of the care of the child. A minor is considered an assisted parental authority. There are no maternity rights for women. She is given six weeks of maternity leave; however, if this is paid or not is decided by the individual company. Availability of social funds helping young mothers from poor families is different from canton to canton. Public health interventions include prevention through sex education, general communication campaigns, and birth control.

Sexual Education

In nearly all regions of the country, sex education classes include information on preventive measures and available services. Sex education classes are conducted at least once a year during middle school age. Sex education while relatively well established in Switzerland, it is not mandatory. Sexual education has a long tradition in Switzerland, starting in the 1970s in the French- and Italian-speaking regions and later developing (in the last 20 years) in the German-speaking region. Depending on the canton, different agencies are in charge of sexual education in schools. It may be the family planning association, school health services, teachers, and in some cases private associations provide it. In most cantons, school nurses are available in schools and serve as referral consultations, as well as, liaison for sexual education sessions. In general, nine out of ten residents in Switzerland have had at least one sexual education lesson. Sexual education includes human immunodeficiency virus (HIV) and sexually transmitted infection (STI) prevention, unplanned pregnancy prevention, and sexual abuse prevention (Balthasar et al. 2004).

Prevention Campaigns

Following the AIDS epidemic, the federal government implemented a national prevention program, recognized as one of the most aggressive campaigns in Europe (Dubois-Arber et al. 1997). This preventive effort is comprehensive, involving STI prevention in its 2010 objectives.

Young people were one of the target groups with messages encouraging the use of condoms in their sexual encounters. A continuous evaluation of this prevention strategy has shown its effectiveness in improving condom-based protection against HIV infection without inducing other major changes in sexual behavior. Population surveys confirm that around 80 % of people ages 16–20 have used a condom at their first sexual intercourse (Narring et al. 2000).

Birth Control

Contraceptive services are available in all cantons through family planning clinics (financed by the government), gynecological private and public clinics, hospitals, and general physicians. All consultations are reimbursed by the mandatory medical insurance.

Conclusion

For the past twenty years, the adolescent birth rate has decreased in Switzerland. A number of important social influences have contributed to this decrease. Greater access to education and professional development for females has become widespread. Moreover, adolescent pregnancy is not necessarily perceived as negative in Switzerland. Often, parents accept their daughter's pregnancy and the fact that she will stay at home.

The preferred method for preventing adolescent pregnancy is encouraging the use of contraception during coitus or postcoital ("morning-after pill"). These prevention programmmes are well established, easily accessible, and confidential. These approaches are considered the primary determinant of the decline in adolescent pregnancy rate. Finally, although unplanned adolescent pregnancy will never disappear,

Swiss medical and social service providers will continue to try and improve contraceptive prevalence and efficacy as well as improve care for adolescent females facing crisis pregnancies.

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