Commentary: adolescent behaviour should be priority

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Early sexual intercourse is commonly associated with a higher number of lifetime sexual partners¹ and, consequently, a higher risk of contracting sexually transmitted infections. From the perspective of sexually transmitted infection, sexual encounters include not only present partners but also past partners and all of their partners' partners. Thus voluntarily delaying sexual debut is of key importance in the prevention of sexually transmitted infections and the promotion of long term health.

The ABC approach to changing sexual behaviour described by Shelton and colleagues can be used as a primary strategy for tackling all sexually transmitted infections. Since the World Health Organization estimates that two thirds of sexually transmitted infections worldwide (including HIV) occur in teenagers and young adults,² prevention programmes must target this population. Given the apparent relation between early sexual intercourse and an increased number of sexual partners, adolescents would benefit from a health oriented approach that includes all components of the ABC approach but specifically recommends abstinence in the form of delayed sexual debut.

It is essential to consider all sexually transmitted infections when determining educational priorities for adolescents. Although condoms reduce the transmission of discharge related infections such as HIV, they provide only limited protection against infections transmitted by skin to skin or skin to sore contact, such as human papillomavirus, syphilis, or chancroid.³ This is because the pathogens are often present on the external genital area as well as the penis or vaginal mucosa.

Compliance issues also impair the effectiveness of condoms. Research shows that most young people use condoms inconsistently over the long term, regardless of knowledge or education. Thus adolescents must be made aware of the realistic risks and benefits of each aspect of the ABC strategy and be encouraged to make decisions that promote optimal health.

Delaying sexual debut

Some proactive interventions are able to change attitudes to sexuality and appreciably increase the

number of adolescents delaying sexual debut or abstaining. In association with the ABC programme, for example, sexual activity among 13 to 16 year olds in one district of Uganda declined from nearly 60% in 1994 to less than 5% by 2001.⁴ In addition, because early adolescent sexual involvement is a common expression of non-sexual need, physicians and public health officials can promote delayed intercourse through educational interventions for parents and teenagers.⁵ The importance of health education that covers early sexual behaviour is highlighted by the Centers for Disease Control: one of the national health objectives for 2010 is "to increase... the proportion of adolescents in grades 9-12 who have never had sexual intercourse."⁶

With sexual lifestyles that often include early onset of sexual intercourse and subsequent serial monogamy, young people are placing themselves at considerable risk of acquiring a sexually transmitted infection. Although partner reduction is a critical and often overlooked component in the ABC strategy, we believe that delayed sexual debut for young people should be the first step in programmes to prevent sexually transmitted infection.

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Health initiatives in poor countries: what can we learn from them?

Most countries are grappling with the problem of rising healthcare costs. Some have more experience than others. Poor countries have long had to live with meagre health budgets. As a result, many have developed innovative, effective, low cost models of care. These often involve the community in a way that is rarely seen in rich countries, where most people are dependant on high tech, institutional based, doctor rich, health services. Identifying models of good practice in resource poor countries and teasing out the reasons for their success and the lessons they provide for the wider health community are the aim of our November theme issue on "Learning from developing countries." To read more about our aims read Tessa Richards' editorial in our 31 January

issue (*BMJ* 2004;328:239-40, <http://bmj.bmjournals.com/cgi/content/full/328/7434/239>).

In this issue we hope to not only flag up models of good practice but also to explore their potential for transfer to other countries; both richer countries and other developing countries. We also plan to look at the lessons that can be learnt from initiatives that fail, particularly those set up by the international community.

To help us identify these models and stimulate debate on their wider potential we are keen to get your views and invite you to send these in as "rapid responses." A digest of these, along with a selection of responses, will appear in the letters section of the *BMJ*'s "Learning from developing countries" theme issue.