The network could serve as a model for other higher education areas based on its expertise in joint curriculum development, quality assurance procedures, mobility arrangements, capacity building and funding processes.

Gender differences in motives and career choice of medical students

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Background
Insight in the choices of medical students concerning their future career is an actual issue, since the population is changing towards a majority of female students. We focus here on insight in the effect of gender and life-stage on students' preferences concerning a medical specialty, and concerning flexible working hours. In addition, this study examines the influence of gender and life stage on motives that direct career choices. On the one hand we relate to extrinsic or instrumental motives and on the other hand intrinsic motives, focused on relational aspects. It can be expected that these motives are mediating the relation between gender and life stage on the one hand and future specialty on the other.
Methods
An online survey was used to gather career preferences of medical students at all Dutch medical universities. Possible preferences for medical specialties were general practitioner and medical specialist, and, in reference to the latter, a surgery or a non-surgery specialty. The measure of life stage consists of the variables study stage (junior and senior students) and living with a partner or not. Motives were measured in terms of extrinsic motives, like salary, status or living situation, next to intrinsic motives, concerning relational aspects, like curing people.
Results
The results present that men aspire a more instrumental medical specialty and handle more instrumental motives then women. Opposite to expectations, study stage did not predict differences in motives or career preferences. A part time preference was larger for senior students than junior students, and especially women preferred working part time. Furthermore, it was found that students living with a partner have other preferences in specialty choice than students living apart. Additionally, students living with a partner have a higher preference for part time work. Finally, motives are partly mediating the relation between gender and living together on the one hand, and preferred specialty on the other hand.
Conclusions
The gender shift in the medical workforce is not automatically followed by a gender shift in career motives and specialty choices. This implies that policy measures are necessary to direct the influx in typical male oriented specialties.

L.4. Workshop: Advances in sexual health

Chairs: Chakib Kara-Zaitri[1], Jelle Doosje[2]*
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Sexual ill health costs European Governments billions of Euros every year and is one of the top six priorities in many countries. All existing Sexual Health surveys highlighted the rising trend of sexually transmitted infections, the link between sexual ill health, poverty and social exclusion and the varying standards of service provision. The findings of these surveys were the catalyst for the development of new ICT initiatives to promote convenient access to consistent, equitable and high quality sexual healthcare.
The workshop aims to explore the effectiveness of:
(1) Surveys for unveiling key data on sexual health and acquiring a deeper understanding of influencing factors such as age, gender, ethnicity, deprivation and sexual orientation.
(2) ICT initiatives for promoting the rights of everyone to have access to healthcare services, improving access to genito-urinary medicine (GUM) services and reducing rates of infection especially for people under the age of 25.
The first aim is discussed in two papers contributed by the Netherlands and the United Kingdom, which present interesting results for the Netherlands and Europe with a strong emphasis to use the findings to inform policy.
The second aim is discussed in two papers outlining two similar ICT initiatives from the Netherlands and the United Kingdom demonstrating an improved registration of sexual health data with an increase in the access and level of clinical care provided to people with sexual health needs across a range of settings.
The findings from the four papers presented provide the following:
(1) Facts as opposed to opinions about the realities of sex and sexuality particularly in the young people community.
(2) A minimum standard of information for registration and subsequent clinical assessment of patients presenting with sexual health issues.
(3) Improved planning, development and evaluation of sexual health services.
(4) A valid local performance management.

The sexual health of young people under 25—the Dutch experience

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Issue
In 2005, a research study entitled 'Sex under 25' was carried out in the Netherlands to investigate sexual health of young people between 12 and 25 years of age. Whilst the overall picture was encouraging, the study unveiled interesting results. For instance, more girls experienced problems with their sexuality (a ratio of one of six) than boys, plus many respondents reported having experienced pain during sex. In addition, 18% of female respondents experienced forced sex in comparison with 26% of homosexual boys. Youngsters starting sex before 14 years have a higher risk of unwanted pregnancy or coerced sex. It was also worrying to note that young people who wanted help often did not know where to seek it.
Intervention
The Ministry of Health (MoH) decided to reinforce sexual health care for youngsters under 25. In 2008, eight regional public health services were set up and made responsible for making sexual health care accessible and available for young people locally. The key objectives of the MoH initiative

included a wide range of facilities such as offering advice on the prevention of unwanted pregnancies, STD, sexual violence and sexual dysfunctions.

Results

Well-trained nurses, doctors and sexologists will provide some 36 000 sexual health consultations per year. An intensive training programme is planned with consultation slots reserved for young people are planned at local places. An efficient marketing exercise is taking place in order to raise the awareness of the new services and encourage appointments based on a walk-in basis.

Lessons

The authors will present their experiences and preliminary results about how effective and efficient the new sexual health services have been. The data presented also include some key metrics such as the number of consultations, the profile of attendees; a categorization of questions asked and a summary of successes and lessons learned.

The sexual behaviours of young people in Europe

Aidan Macfarlane

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International Independent Consultant in Adolescent Health, UK

Issue

The sexual health of young people is of intense concern because of its public health implications including wanted and unwanted pregnancy, abortion issues, contraception and sexually transmitted infections. There are all kinds of myths about the sexual behaviour of young people. There is an urgent need to move away from opinion to fact and use this to inform strategy and policy.

Intervention

This article describes in detail the findings of a useful comparative study of sexual health in different countries across Europe—the Health Behaviour of School-aged Children. The average percentage of 15-year-olds who had sexual intercourse was 20% for girls and 28% for boys with a variation across countries of between 4% and 79% for girls and 1%8 and 71% for boys. Rates were lower in Spain, and eastern and central Europe and higher in Greenland, the Ukraine and the UK.

Results

On average of young people who were sexually active 70% of girls and 80% of boys reported using a condom at the time of last intercourse. Amongst girls, the rates of contraceptive use were lowest in Croatia, Hungary, Poland, Scotland and Ukraine and highest in the Netherlands and Switzerland. There is unfortunately a lack of studies on the actual detailed range of sexual activities that young people try. An exception is a study of young people carried out in Scotland, which indicated that among 14-year-olds over 70% had kissed, around 40% had gone in for 'heavy petting', around 15% had performed oral sex and about the same number had full sexual intercourse. The last two sexual behaviours were slightly more common in girls than boys.

Lessons

Findings from the above study and indeed other comparative studies relating to sexual behaviours need to inform sexual health strategy and policy.

The development of a sexual health registration system in the Netherlands

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Issue

In September 2007, the Ministry of Public Health in the Netherlands issued an act focused on the regulation and implementation of easily accessible, free and short-term sexual health services for young people. This represented a new programme of work for the departments of Infectious Disease Control and allows the Ministry to closely monitor the consultations carried out nationwide.

Intervention

The aim of the new system was to develop a flexible database, which can readily handle the varying needs and expectations of the various regions as well as provide a practical and useful tool for supporting sexual health professionals during their consultations. There were many challenges, particularly during the design stages of the database, including the specification of a number of domain values such as the primary sexual themes.

Results

The article highlights the challenges involved in designing the software. For instance, the work required by experts to identify and classify the main and subthemes in essential health data. The system provides greater support for the health professionals, as well as a better data set. It will be possible to obtain background information per theme directly from the handbook. Phase 1 of this work focused on the 'Information Analysis' and took considerable time to complete.

Lessons

The article explores the database design and the associated user interface. The work completed to-date clearly shows that the key objectives have been met. The new registration system improves the registration process and supports the health professional obtain key data in an organized manner. The registration system as such cannot be used as a tool to improve the quality of consultations. The key lessons learned included regular consultations with all parties concerned.

SHFirst: a web-based decision support system for sexual health in the United Kingdom

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Issue

The past decade has been marked by a deterioration in the UK's sexual health with growing levels of HIV and sexually transmitted infections. Increasing waiting times to access NHS genito-urinary medicine (GUM) services has exacerbated the situation. In 2005, the Department of Health established a Public Service Agreement target requiring the percentage of patients attending GUM clinics who are offered an appointment to be seen within 48 h of contacting a service to reach 100% by 2008.

Intervention

A smart web-based Sexual Health Decision Support Suite called SHFirst has been designed and successfully implemented in four clinics in the Bradford and Airedale Area to meet the 48 h GUM access targets.

Results

SHFirst Phase 1 consists of the four interconnected modules:
(1) The Telephone Contact Centre Module: to record/update basic or pseudo details of the caller and symptoms, carry out a triage and determine the level of service required, offer the caller an appointment at all participating clinics within 48 h of the call and record the caller choice and associated details.
(2) The Reception Module: to manage patient arrivals with a new episode of care, planned and unplanned walk-ins, booked appointments, follow-ups, as well as store some clinical notes.
(3) The Reporting Module: to compute 20 metrics required for audit purposes to meet the 48 h GUM access targets.

(4) The Admin Module: to set up complex rotas based on appointments only, walk in, protected and reserved slots at the participating clinics.

Lessons

SHFirst can readily provide:

(1) monitoring and performance management of the 48 GUM access targets,

(2) accurate data on the demand for services and opportunities to improve capacity planning,

(3) Rich data about the difficulties patients may have in accessing services and

(4) Rich data set commensurate with the Common Sexual Health Data Set.

M.4. Presentation on the Report of the Commission on Social Determinants of Health

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Three years ago, the World Health Organization launched the Commission on Social Determinants of Health. Chaired by Sir Michael Marmot, and comprising Commissioners drawn from all parts of the world and from academia, politics and civil society, the report concludes that the 'toxic combination of bad policies, economics, and politics is, in large measure, responsible for the fact that a majority of people in the world do not enjoy the good health that is biologically possible' and challenges the world community to achieve global health equity 'with a generation' a goal that 'is achievable, it is the right thing to do, and now is the right time to do it.'

The report sets out three areas for action: improve daily living conditions; tackle the inequitable distribution of power, money and resources; and measure and understand the problem and assess the impact of action.

This provides both a challenge and an opportunity to EUPHA. A major conference presenting the report is taking place in London, coinciding with the EUPHA conference. However, to ensure involvement of EUPHA members in this process, this session will connect to the London conference, with broadcasts of keynote speeches followed by commentaries by those at the conference in London exploring the relevance of the Commission's report to the European public health community. The session will then move to a facilitated discussion among those present in Lisbon to explore possible next steps. A limited number of copies of the report will be available at the session. Session supported by the English Department of Health