

Youth-friendly

health policies and
services in the
European Region

Sharing experiences





EUROPE

Youth-friendly health policies and services in the European Region

Sharing experiences

Editors: Valentina Baltag and Alex Mathieson

ABSTRACT

This publication presents experiences of how health systems in Member States of the WHO European Region respond to the challenge of meeting the health and developmental needs of young people. The main aim is to facilitate experience-sharing and stimulate actions in countries.

The first part presents a summary of the proceedings of the Meeting on Youth-friendly Health Policies and Services held in Edinburgh, United Kingdom (Scotland), 21–23 September 2009, with suggestions to inform decision-makers' actions on creating and developing youth-friendly health policies and services in their own countries and internationally. There then follows a series of 12 case studies from nine countries with differing socioeconomic contexts that recently put in place youth health services initiatives. The case studies are presented within a health system framework which recognizes that for service delivery to achieve its aims, sustainable financing, adequate human resource development strategies and responsible leadership are necessary.

Keywords

ADOLESCENT HEALTH SERVICES - organization and administration
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This publication is based upon the report writer's/editors' interpretations of verbal presentations and group discussions at the Meeting on Youth-friendly Health Policies and Services held in Edinburgh, Scotland on 21–23 September 2009, screen presentations and written papers prepared as part of the meeting process. The publication does not necessarily represent the views of the World Health Organization, meeting co-organizers or participants at the meeting (including presenters, case study authors and break-out group facilitators).

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Acronyms

| | |
|--------|--|
| A&E | Accident and emergency (United Kingdom) |
| AFP | Associação de Planeamento Familiar [Family Planning Association] (Portugal) |
| AHP | Adolescent health project (United Kingdom (England)) |
| AIDS | Acquired immune deficiency syndrome |
| AVSC | Association for Voluntary Surgical Contraception International |
| BCG | Bacille Calmette-Guérin (vaccination against tuberculosis) |
| BME | Black and minority ethnic |
| BRIS | Barnens Rätt i Samhället [Children's Rights in Society] (Sweden) |
| BZgA | Bundeszentrale für gesundheitliche Aufklärung [Federal Centre for Health Education] (Germany) |
| CAJ | Centro de atendimento de jovens [youth attendance centre] (Portugal) |
| CAMHS | Child and adolescent mental health services |
| CHCP | Community health and care partnership (United Kingdom (Scotland)) |
| CIA | Central Intelligence Agency (United States) |
| CICO | Centrul de Instruire si Consultanta Organizationala [Centre for Education and Organizational Consultancy] (Republic of Moldova) |
| CiNTRA | Centro Integrado de Tratamento Ambulatorial e de Reabilitação [the Integrated Centre for Outpatient Treatment and Rehabilitation] (Portugal) |
| CIS | Commonwealth of Independent States |
| CoE | Council of Europe |
| COPE | Client-oriented, provider-efficient |
| CPP | Community planning partnership (United Kingdom (Scotland)) |
| CRC | United Nations Convention on the Rights of the Child |
| DGIDC | Direcção-Geral de Inovação e de Desenvolvimento Curricular [Director-General of Innovation and Curricular Development] (Portugal) |
| DICE | Drama Improves Lisbon Key Competences in Education |
| EC | European Commission |
| EGAL | Equality for Gays and Lesbians (the former Yugoslav Republic of Macedonia) |

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|---------|--|
| ENHPS | European Network of Health Promoting Schools |
| EU | European Union |
| EUSUHM | European Union for School and University Health and Medicine |
| EuTEACH | European training in effective adolescent care and health (Switzerland) |
| EVA | Especially vulnerable adolescents |
| EYF | European Youth Forum |
| FMH | Faculdade de Motricidade Humana [School of Human Kinetics] (Portugal) |
| FSNK | Federal Narcotics Control Service (Russian Federation) |
| GDP | Gross domestic product |
| GFATM | Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria |
| GP | General practitioner |
| GTES | Grupo de Trabalho para a Educação Sexual/Educação para a Saúde [Working Group on Sexual Education/Health Education] (Portugal) |
| HBSC | WHO Health Behaviour in School-aged Children study |
| HEADSSS | Home and peers; education; activities: drugs; safety; sex; suicide |
| HEI | Higher education institution |
| HERA | Health Education and Research Association (the former Yugoslav Republic of Macedonia) |
| HIV | Human immunodeficiency virus |
| HOPS | Healthy Options Project Skopje (the former Yugoslav Republic of Macedonia) |
| HPV | Human papillomavirus |
| IAC | Instituto de Apoio à Criança [Child Care Institute] (Portugal) |
| ICPD | International Conference on Population and Development |
| IDA | International Development Association |
| IDP | Instituto de Desporto de Portugal [Sports Institute of Portugal] (Portugal) |
| IDT | Instituto da Droga e toxicodependência [Institute for Drugs and Drug Dependency] (Portugal) |
| IDU | Injecting drug user |

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|------------------|--|
| IEC | Information, education and communication |
| INE | Instituto Nacional de Estatísticas [National Institute of Statistics] (Portugal) |
| IPJ | Instituto Português da Juventude [Portuguese Institute for Youth] (Portugal) |
| IPPF | International Planned Parenthood Federation |
| IPPF EN | International Planned Parenthood Federation European Network |
| ISO | International Organization for Standardization |
| IT | Information technology |
| IUD | Intrauterine device |
| JOTER | Jovens à Terça [Youth on Tuesdays] (Portugal) |
| KAP | Knowledge, attitudes, practice |
| LGBT | Lesbian, gay, bisexual or transgender |
| MAPS | St Petersburg Medical Academy of Postgraduate Studies (Russian Federation) |
| MDGs | Millennium Development Goals |
| MDM | Médecins du Monde [Doctors of the World] |
| MDT | Multidisciplinary team |
| MI | Motivational interviewing |
| MMI | Mandatory medical insurance (Russian Federation) |
| MSM | Men having sex with men |
| NCA | Norwegian Church Aid |
| NES | Núcleo de Estudos do Suicídio [Centre for the Study of Suicide] (Portugal) |
| NGO | Nongovernmental organization |
| NHIF | National Health Insurance Fund (Republic of Moldova) |
| NHS | National Health Service (United Kingdom) |
| NSF | National service framework (United Kingdom (England)) |
| OSI | Open Society Institute (the former Yugoslav Republic of Macedonia) |
| Pap (smear test) | Papanicolaou smear test |

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| PCT | Primary care trust (United Kingdom (England)) |
| PHC | Primary health care |
| PISA | Programme for International Student Assessment |
| PORI | Plano Operacional de Respostas Integradas [Operational Plan for Integrated Responses] (Portugal) |
| PNSJ | Plano Nacional de Saúde Juvenil [National Youth Health Plan] (Portugal) |
| PSHE | Personal, social and health education |
| RESAPES –AP | Rede dos Serviços de Aconselhamento Psicológico do Ensino Superior – Associação Profissional [Psychological Support Services in Higher Education Network – Professional Association] (Portugal) |
| SALSUS | Scottish Schools Adolescent Lifestyle and Substance Use Survey (United Kingdom (Scotland), Dundee) |
| SHARE | Sexual Health and Relationships Education (United Kingdom (Scotland)) |
| SHE | Schools for Health in Europe |
| SHS | School health services |
| SIMD | Scottish Index of Multiple Deprivation (United Kingdom (Scotland), Dundee) |
| SRH | Sexual and reproductive health |
| SSRM | Soviet Socialist Republic of Moldova |
| STI | Sexually transmitted infection |
| TEMPEST | Temptations to Eat Moderated by Personal and Environmental Self-regulatory Tools |
| UMSA | Unité Multidisciplinaire de Santé des Adolescents (Switzerland) |
| UNAIDS | United Nations Joint Programme on HIV/AIDS |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations International Children’s Fund |
| USAID | United States Agency for International Development |
| VCT | Voluntary counselling and testing |
| VIEW | Values, rights, confidentiality, the law (training) (United Kingdom (Scotland), Dundee) |
| VS | Vocational schools |

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| WHO | World Health Organization |
| YFC | Youth-friendly clinic |
| YFHC | Youth-friendly health centre |
| YFHS | Youth-friendly health services |
| YFHCS | Youth-friendly health care services |
| YFS | Youth-friendly services |

Foreword

In September 2009, an article on global patterns of mortality among young people, co-authored by staff from the World Health Organization's (WHO's) Department of Child and Adolescent Health and Development, was published in *The Lancet*. It summarized the results of the first study to estimate causes of death among this age group, and showed that globally, 2.6 million young men and women die each year. In the WHO European Region, more than 300 young people die *every day* from largely preventable causes – just when they start to be productive members of society. Almost one in ten 18-year-olds in the European Region suffers from depression. We can no longer assume that being young necessarily means being strong, fit and happy. Nor can government policies afford to overlook the health and developmental needs of this age group.

At the WHO European Ministerial Conference on Health Systems, Health and Wealth, which took place in June 2008 in Tallinn, Estonia, WHO committed to support its European Member States in the development of their health systems not only to produce health, but also to generate wealth. The Tallinn Statement is particularly important for the health of young people, who are central to the future wealth and well-being of our societies.

In recent years, governments in the European Region have made progress in putting in place “youth-friendly” health policies and services. However, much more needs to be done to maximize the benefits of these efforts, and to make them sustainable. We believe that strengthening health systems' responsiveness to young people's needs is a way to achieve this. This means ensuring steady progress in all health system building blocks: *service delivery*, by making services available, accessible and appropriate; *resource generation*, by ensuring that a health workforce with the right skills and competencies is in place; *financing*, by ensuring commitment to allocating financial resources for both mainstream and specialized services; and *leadership*, by having policy-makers and decision-makers convinced that investing in young people's health is the right thing to do, both from a human rights perspective and because it is money well spent.

This report summarizes the deliberations of a meeting on the present and future of youth-friendly health policies and services in the European Region held in Edinburgh, United Kingdom (Scotland) in September 2009, which brought together representatives from 35 Member States of the European Region. In reading this report, it is clear how much is already being done, and how much countries stand to gain from sharing experience. We say “experience” and not “best practice”, as what is best in the United Kingdom might not work in Georgia, and vice versa. But what the report clearly demonstrates is that innovation is there and successes are achievable. The meeting's suggested action areas are also helpful in developing understanding of what can be done to transform successful projects into overall improvements for systems and routine practice.

The case studies that complement this meeting report provide the opportunity to dip into one or another country experience of delivering innovative and socially and culturally acceptable health programmes and services for young people. We believe that the richness of the case studies is not merely in their description of a particular kind of youth-friendly service delivery model – be it a youth clinic, paediatric specialized facility or primary care service – but in putting it into context:

- *the sociodemographic and cultural context*, to help us understand the broader spectrum of influences to which a young person in, for example, the Russian Federation, is exposed;
- *the health systems context*, to help us understand, for example, how school health service provision in the Republic of Moldova is affected by health system reform; and
- *the legislative and policy context*, to illustrate how the United Nations *Convention on the Rights of the Child* can be a very practical instrument in promoting the health of young people and can actually influence, through various mechanisms of participation, the kind of services made available, as described in the case study from Sweden.

It is our conviction that a young person is as important a client of health services as a newborn and an older person. By facilitating experience-sharing, putting together evidence and a range of practices and making them available for a wide audience, we hope to contribute to moving government agendas forward in strengthening health systems to better respond to the health and developmental needs of young people in all countries of the European Region.

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Introduction

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In recent years, Member States of the WHO European Region have made progress in supporting health services to be more responsive to young people's health and development needs and in creating a supportive policy environment to enhance services' accessibility. This publication highlights experiences of how health systems in Member States respond to the challenge of meeting the health and developmental problems of young people.

The publication presents not only the report of an international meeting, but also a series of country case studies. The two distinct parts of the publication complement and support each other – indeed, drafts of the case studies were provided to meeting participants to inform their thinking and discussions at the meeting – and their power would be diminished if presented separately.

The publication begins with a summary of the proceedings of the Meeting on Youth-friendly Health Policies and Services held in Edinburgh, United Kingdom (Scotland), 21–23 September 2009. This was an exciting international meeting involving participants from 35 countries of the European Region, representatives of the European Youth Forum (EYF) and young people.

The meeting was organized by WHO Regional Office for Europe in collaboration with NHS Health Scotland, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the International Planned Parenthood Federation European Network (IPPF EN) and the European Training in Effective Adolescent Care and Health (EuTEACH) group. It aimed to create a forum for experience-sharing across Member States and to contribute to efforts to move forward government agendas in strengthening health systems to better respond to the health and developmental needs of young people, including those most at risk.

You will find that the first part of the publication reports on presentations and discussions across the main themes of the meeting, which were: putting in place a supportive legislative and policy environment for youth-friendly health services; specific experiences from each country on supportive legislative and policy environments; answering the need for quality in youth-friendly health services; enabling youth-friendly services to reach most-at-risk adolescents; health care at school; countries' examples aligning school health services with pupils' needs; and human resources for adolescent health.

You will also find summaries from the tool-based workshops in this part. These workshops offered participants the opportunity to learn about selected tools for the development, implementation and evaluation of policies and services for young people, including training packages available in the region, and the use of technology for professional education and engaging youth.

We are sure you will find the next section – the suggested action areas from the meeting that we hope will support decision-makers in creating and developing youth-friendly health policies and services in their own countries and internationally – particularly useful.

The suggested actions are based on research evidence presented at the meeting and the experience of participants representing a wide range of government agencies and national and international organizations concerned with youth health. They also reflect the views of young people elicited from an EYF survey commissioned for the meeting. Overall, the suggested actions to improve youth-friendly health services and policies recommended by young people participating in the survey were similar to those recommended by meeting participants. Where this was not the case, the report specifically highlights those generated by the survey.

The suggested actions focus on important aspects of health system functioning, such as supportive policies, financing and health care workforce capacity, youth-friendly health service delivery, partnerships and leadership.

In the second part of the publication, we present case studies on the organization of health care services for young people in nine countries: Georgia, Portugal, the Republic of Moldova (two case studies), Russian Federation, Sweden, Switzerland, the former Yugoslav Republic of Macedonia, Ukraine and United Kingdom (three case studies).

Our main aim in identifying the case studies was to reflect a mix of countries with different socioeconomic characteristics in which youth health initiatives are already part of, or explicit attempts are being made to make them part of, health care delivery systems.

Most of the case studies follow a common template we have developed, focusing on three key areas:

- a detailed examination of the current situation with regard to the economic, sociocultural and demographic context affecting young people in the country, their health and development needs and the country policy and health system context, including health services currently available to young people;
- a description of a recent initiative aiming to strengthen health service delivery for young people; and
- lessons learnt from the initiative's implementation, with suggested ways forward.

The case studies are set within a health system framework which recognizes that for service delivery to achieve its aims, sustainable financing, adequate human resource development and responsible leadership are necessary.

You should note that while the country case studies were based on a common template, we did not attempt to impose a rigid and uncompromising structure on the case study authors. We wanted their studies to reflect the differences in the types of initiatives being described and the context of implementation in the different countries. An inflexible structure may have compromised this aim, so the template was offered for guidance only.

We hope you will see this publication as a step forward in supporting actions in Member States to address the challenges of promoting young people's health and development.

Acknowledgments

This publication has emerged as the result of a strong vision, excellent partnerships, and hard work involving many people at the WHO Regional Office for Europe and WHO headquarters, and in Member States. We are especially grateful to NHS Health Scotland for co-hosting and organizing the event, and whose experience in supporting youth-friendly services through their innovative "Walk the talk" initiative proved invaluable. NHS Health Scotland's Nuala Healy played a particularly important role before, during and after the event and was a key driving force behind its vision, inception and successful delivery.

We are grateful to all those who organized, participated in and supported the Meeting on Youth-friendly Health Policies and Services. Special thanks to all speakers and the members of the planning group, whose vision and inspired ideas made the meeting a lively event: Gunta Lazdane, Isabel Yordi, Vivian Barnekow from WHO Regional Office, Nuala Healy from NHS Health Scotland, Elizabeth Bennour from IPPF EN, PA Michaud, head of the EuTEACH group, and the administrative support team: Olga Pettersson, Ida Stromgren and Natalia Olesen from WHO Regional Office, and Nicola Thomson, Gemma Mills and Mark McGaughrane from NHS Health Scotland.

Many thanks to the Scottish Government, who demonstrated their strong commitment to youth-friendly

services by hosting a Ministerial reception for participants, and to the Scottish Youth Theatre, who presented an engaging and thought-provoking performance at the event.

We gratefully thank the case study authors for their contributions and cooperation during the editorial process, and Chandra-Mouli Venkatraman and Virginia Camacho from WHO headquarters, who made useful suggestions for the case study outline. We appreciate the thoughtful suggestions of people who coordinated the development of and reviewed the case studies from their country: Larisa Lazarescu and Sergiu Tomsa from UNICEF in the Republic of Moldova, Anastasiya Dumcheva from WHO Country Office in Ukraine, and Olena Sakovych from UNICEF Ukraine. We also appreciate the help of Peer Sieben, UNFPA Country Director for Armenia, Azerbaijan and Georgia, and Nina Ferencic, Regional Advisor, HIV/AIDS, UNICEF Regional Office in Central and Eastern Europe and the Commonwealth of Independent States, who contributed to the identification of good experiences through their organizations and encouraged their counterparts to answer the call for case studies.

We gratefully acknowledge the time taken by Paul Bloem and Marcus Stahlhofer from WHO headquarters in reviewing the meeting report; we benefited greatly from their helpful comments. And we are especially grateful to Alex Mathieson for compiling the meeting report and editing the publication, Jane Persson for managing the production process of the publication, and Nikolai Chaika for editing the Russian version.

Meeting on Youth-friendly Health Policies and Services

Edinburgh, United Kingdom (Scotland), 21–23 September 2009

Meeting context, summary report and suggested action areas

Meeting context

In recent years, Member States of the WHO European Region have made progress in making health services more responsive to young people's health and development needs and in creating a supportive policy environment to enhance services' accessibility. Governments are supported in their efforts by national and international communities, including service providers, bilateral agencies, national and international nongovernment organizations (NGOs) and United Nations agencies, which provide support for various aspects of adolescent health and development work.

Within this context, the WHO Regional Office for Europe focuses its support to Member States on strengthening health systems' responsiveness to the health and developmental needs of young people. Particular attention is paid to increasing the availability and use of evidence-based strategic information, promoting an enabling policy environment and improving the quality of care.

Despite ongoing government efforts, much more needs to be done before services become widely accessible to young people regardless of their socioeconomic circumstances. The issues of quality of existing services and coverage with effective interventions still need to be addressed. So far, little effort has been put into enabling primary care practitioners to deliver services that are sensitive to young people's needs, and there is a lack of experience in ways of effectively reaching most-at-risk adolescents. The potential of school health services, where available, to contribute effectively to health and development outcomes of school-age children is underexplored.

While these challenges relate more to the ways services for young people are organized, their use might also be impeded by prohibitive norms and policies. Issues such as age-related competency for informed consent and privacy and confidentiality have not yet been properly addressed. Countries are still some way short of aligning their legal and policy framework with the international human rights conventions that many of them have ratified.

In line with these developments, and in order to follow up on the recommendations of the WHO meeting of national focal points for family and community health (25–28 September 2006, Malaga, Spain), the WHO Regional Office for Europe, in collaboration with NHS Health Scotland, the United Nations Children's Fund (UNICEF), the United Nations Population Fund (UNFPA), the International Planned Parenthood Federation European Network (IPPF EN) and the European Training in Effective Adolescent Care and Health (EuTEACH) group, organized a meeting on youth-friendly health policies and services for representatives from Member States of the WHO European Region, United Nations agencies and partner organizations.

Meeting summary report

Meeting aims and objectives

Aims

- To create a forum for experience-sharing across Member States.
- To contribute to efforts to move forward government agendas in strengthening health systems to better respond to the health and developmental needs of young people, including those most at risk.

Objectives

- To present current trends and evidence on the health and development of young people in the WHO European Region, and discuss their implications for health care organization.
- To share experience across Member States of the WHO European Region on youth-friendly health policies and services development.
- To advocate for the need to strengthen health systems to better respond to young people, including those who are most at risk.
- To discuss specific implications for primary care and school health services.
- To suggest action areas for creating supportive legal and policy environments and service development.

Meeting day 1

Opening session

The meeting was opened by **Margaret Burns, CBE, chair of NHS Health Scotland**, who welcomed participants and reminded them that this was not a meeting *about* young people, but was a meeting *with* young people. Ms Burns emphasized the importance of partnership approaches in meeting the health needs of young people, which she identified as a priority area for NHS Health Scotland. Partnerships needed to be forged at cross-agency and cross-government levels, she claimed, as a wide range of sectors impact on the health of young people.

Shona Robison, MSP, Minister for Public Health and Sport, Scottish Government, explained that the Scottish Government also places a high priority on the health of young people, with an integrated approach to the issue being adopted across all government portfolios. Young people in Scotland still face significant health challenges in areas such as teenage pregnancies and STIs, but government measures to combat these are beginning to have an effect. Health inequalities remain a challenge in Scotland, as elsewhere, the Minister explained, and it was important to set youth-friendly services within the wider frame of health inequalities. The Ministerial Task Force on Health Inequalities in Scotland is a strong example of good cross-sectoral working in this area. Ms Robison stressed the need for engagement with young people in the design and delivery of policy and services, and urged participants to take account of young people's views when forming their suggested action areas.

Elizabeth Mason, Director, Department of Child and Adolescent Health and Development, WHO headquarters, told participants that while most adolescents are healthy, some are not, and others will adopt behaviours that put them at risk. Each year throughout the world, 2.6 million young people die. While young people in the WHO European Region tend to be healthy, this is not always the case: young men in eastern Europe, for instance, are at higher risk of homicide, road traffic accidents and suicide – all preventable causes of death and injury. Dr Mason stressed that identifying and understanding adolescent health behaviours was key to developing appropriate policies and services. A supportive legal environment was also necessary. She reminded participants that 2009 marks the twentieth anniversary of the United Nations *Convention on the Rights of the Child (1)*, and there was a need to ensure that laws and policies were not only based on evidence, but also on human rights standards.

Enis Bariş, Director of the Division of Country Health Systems, WHO Regional Office for Europe, reminded participants that the title of the WHO Ministerial Conference on Health Systems held in Tallinn, Estonia, in June 2008 reflected the idea that “health is wealth”. This is a particularly relevant idea in relation to youth health, he said, because the young people of today are the wealth creators of tomorrow. The *Tallinn Charter: Health Systems for Health and Wealth (2)* emerging from the ministerial conference identified four key functions of health systems: service delivery; financing; resource generation; and stewardship. It is imperative that health systems work across all four functions in order to achieve maximum outcomes. Dr Bariş urged that health services be made youth-friendly and geared to the needs of young people. Young people assess their health and health risk differently from adults, he said, and services need to reflect this in their planning. But making services available is not enough, he suggested – the services have to be accessible, tactful and confidential, and they have to be staffed by professionals with appropriate training in meeting young people’s needs.

Putting in place a supportive legislative and policy environment for youth-friendly health services: what can we learn from each other?

The session began with a presentation by **Paul Bloem, Department of Child and Adolescent Health and Development, WHO headquarters.** Dr Bloem said that work on developing health services for adolescents was a joint endeavour in Europe in which partnerships are crucial.

Mr Bloem argued that there are demographic, public health, socioeconomic and human rights reasons for focusing on adolescent health. Demographically, there are 1.4 billion adolescents worldwide, with 95 million in Europe, but the population of adolescents will reduce – which means now is the window of opportunity for action. In relation to public health, two thirds of premature deaths and one third of total diseases in adults are attributable to behaviours developed in adolescence, so understanding adolescent behaviour is key to developing effective public health approaches.

The economic case, he suggested, is simply that “health is wealth”. Adolescents are the wealth creators of the future, so future prosperity depends on their health. And the human rights case is that human rights provide us with the standards by which we can measure progress in legislative and policy development.

WHO’s assessment is that much progress has been made over the last 10 years in terms of building adolescent-friendly health services, with 25 countries now having such services in place, Mr Bloem reported, but quality and coverage remain uneven.

Candace Currie of the Child and Adolescent Health Research Unit, University of Edinburgh, United Kingdom (Scotland), who is the **Health Behaviour in School-aged Children (HBSC) study international coordinator,** then reported on the health and sociocultural issues affecting adolescents in the European Region. She referred to a new publication from WHO, the *Snapshot of the health of young people in Europe* report (3), which provides an overview of systematic data (mainly derived from the HBSC study) on health and health inequalities among 11–25-year-olds. The report demonstrates, she said, that there are very poor data on children outside the education mainstream and young people under the age of 11 and over 16 years, and that disaggregated data are difficult to locate.

The HBSC study now covers 43 countries, Professor Currie reported, but new countries are always welcome. The most-recent HBSC international report (4) focuses on inequalities. It highlights key issues for policy-makers and services which emphasize that while adolescents are commonly considered to be healthy, they face persistent health challenges that affect their current and future well-being. Significant variation exists in the experience of health and well-being among adolescents across Europe, she claimed, with economic, social, age, gender, cultural and environmental factors contributing to inequalities in health and risk within and between countries. Professor Currie challenged policy-makers and services to ensure they addressed the needs of all young people, not just those in the mainstream, and called for the development of new research methodologies and networks to facilitate the collection of health data on non-mainstream young people.

Marcus Stahlhofer, human rights adviser at the Department of Child and Adolescent Health and Development, WHO headquarters, discussed how laws and policies could be strengthened through human rights. He emphasized that the basic principle of the *Convention on the Rights of the Child (1)* is that society has an obligation to meet the essential needs of children and to provide assistance for the development of their personality, talents and abilities. When a state ratifies the convention, the obligations under the convention become legally binding. Adopting a “rights-based” approach to developing laws and policies therefore means that these obligations are recognized and upheld, ensuring that the needs of children and adolescents are met.

Mr Stahlhofer suggested that the convention can support the development and implementation of law and policies directed at improving well-being of all adolescents by helping to ensure they are based on accountability through legal obligations, promote non-discrimination and equity, and are developed through multisectoral collaboration, participation and international cooperation.

The session closed with a performance by the **Scottish Youth Theatre** which, in a humorous but sensitive way, explored the issues and challenges young people face when accessing conventional health services. Prominent among these were issues about access at times that suit young people, appropriateness of reception and treatment areas, privacy, confidentiality, communication and respect for personal choice.

Outcomes and discussions from this session are reflected in suggested action areas 2, 3, 4, 10, 11, 12 and 37.

Specific experiences from each country on supportive legislative and policy environments

Participants heard five brief presentations, which are summarized below.

Switzerland Key issues in Switzerland are access, quality and the rights of young people to make decisions.

- Access: young people under 20 years have medical insurance, including young immigrants, some of whom are minors with no parents and/or are in the country illegally. They have rights to health care regardless of status.
- Quality: there is no network of youth health centres, but there are family planning centres that are well-known to young people. Efforts are being made to spread information about the centres to those who are most at risk. In the French-speaking part of the country, an international professional training initiative on adolescent health has been set up.
- Decision-making: competent minors are enabled through an article in the civil code to make decisions on their own health, including the right to make a decision that goes against their parents' will. There is no age limit for the acquisition of competency; professionals must make judgements on a case-by-case basis, taking into account the complexities of each situation, which is not easy.

Tajikistan Tajikistan has a strong legal framework that promotes youth-friendly services, but implementation of policy is challenging, and sustainable resources are not always available. An analysis of national laws, policies and regulations from the adolescent health perspective is being carried out, and results are exposing discrepancies between civil and criminal codes which can give rise to conflict on, for instance, the legal age for marriage. Sex under the age of 16 years is illegal, and doctors are required to report to the police any young person under 16 who comes to them and confesses to having sex, which negates notions of confidentiality. Similarly, contraception and abortion can only be offered with parental consent. The Ministry of Health is working with stakeholders to effect changes in laws and policies, but this will not happen overnight.

United Kingdom (England) The Children Act 2004 is pivotal in the drive to develop evidence-based policy in England. The “Every child matters” framework is now enshrined in education inspection processes, which includes evaluation of the delivery of health education. The national *Children's plan (5)* is based on wide

stakeholder participation and reflects what young people say they need and want from services. *Healthy lives, brighter futures* (6) acknowledges that adolescence is a key time in the life-course and calls for the development of transition services. The “Gillick competence” defines whether a young person under 16 years is competent to consent to medical treatment without parental consent, and the “Fraser guidelines” define that it is lawful for doctors to provide medical advice and treatment to under-16s without parental consent providing certain criteria are met. These criteria include, crucially, that the young person is capable of understanding the advice given and the implications of proposed treatment and that the provision of medical advice and treatment is in his or her best interests, with a likelihood that his or her physical and/or mental health would suffer in its absence. In practice, interpretation of these broad guidelines is challenging for practitioners. Confidentiality is a complex area which places great pressure on health practitioners. The guidelines are clear that a practitioner’s personal beliefs should not prejudice the care of a young person, and that if the practitioner is not prepared to honour the young person’s confidentiality, the young person should be referred on to another appropriate practitioner. It is important to reflect young people’s views in the development of policy and guidelines on confidentiality and to ensure they are involved early in determining their needs and how they can best be met.

European Commission (EC) Youth health is important to the EC and appears in various policy initiatives, and the EC co-hosted a conference on youth health with the European Youth Forum in July 2009. Youth health in Europe is good with low levels of chronic disease and mortality, but there are some worrying trends in relation to alcohol use, addictions and injuries. These create room for EC interventions, and a “roadmap” of actions to improve youth health is being drafted. The roadmap’s main priorities are: promoting youth empowerment and participation; communicating about health in youth-friendly ways; and addressing inequalities and vulnerability. The aim is to mainstream these three principles in policies from all sectors. The EC is now working multisectorally to promote youth health issues and has established a youth task force.

European Youth Forum (EYF) The EYF is a platform of around 100 youth organizations. Its mission is to ensure policy-makers hear the voice of youth, working in partnership with organizations such as WHO, the European Union (EU), the EC, the United Nations and the Council of Europe (CoE) on all areas of interest to young people. Its current work on health focuses on youth-friendly services, health policy, gender issues and sexual and reproductive rights. It is also working with the EU on an anti-tobacco campaign. The EYF considers itself a “work in progress”. Initially, it believed it represented the “token” youth voice, but it is now widely recognized that it makes a tangible and very valuable contribution. EYF’s wide and diverse membership enables it to reach out to and influence many systems and organizations (health and non-health) in powerful positions. The EYF believes that:

- young people need to be involved at all levels of health policy development and implementation, health campaigns and conference organization and delivery;
- youth involvement must not be tokenistic; and
- health systems need to look at new ways of communicating with young people using mobile phone and Internet technology and social networking sites.

Outcomes and discussions from this session are reflected in suggested action areas 1, 2, 8 and 36.

Meeting day 2

Answering the need for quality: youth-friendly health services

Valentina Baltag, Division of Country Health Systems, WHO Regional Office for Europe, opened the session by focusing on strengthening health systems for youth-friendly health services (YFHS). She emphasized that taking a health system approach is crucial when planning, implementing and improving YFHS. While there is a variety of models of YFHS in the European Region, no evidence has so far emerged to support one model over the others. She stressed that the decision on which model to adopt or develop

should be based on young people's identified needs in the particular country or area and health system context.

A number of specific issues in financing mechanisms in countries across the European region discriminate against the provision of YFHS, Dr Baltag claimed. These, she suggested, limit young people's access to services and, in some countries, raise serious questions about the sustainability of YFHS. Ensuring sustainable financing is linked to the ability to demonstrate the impact of the service on the health and well-being of young people.

The development of an adequate workforce for YFHS relies on matching skill-mix initiatives to the selected service delivery models. Quality and coverage measurements are important, and being clear about the scope of the service and the specific contribution it can make to young people's health and development should be the starting point for quality assurance initiatives, Dr Baltag said.

Dick Churchill, Chair of the Adolescent Health Group of the Royal College of General Practitioners of the United Kingdom, addressed the issue of age-appropriate primary care. Dr Churchill claimed that the following factors, grouped under the acronym "ACT", are crucial to ensuring the primary care system works for young people.

- **Appropriate access, awareness, attitudes and authenticity.** Relevant services are about offering young people access at relevant times, to relevant places and to relevant professionals. Young people need to be aware that primary care services offer other kinds of services in addition to biomedical, such as counselling and psychological support services. Policies and documents don't change professionals' attitudes for the better – it is down to individual practitioners to work on improving their attitudes. And authenticity is about being genuine and truthful in what practitioners say and do – young people need to believe that what practitioners say is what they actually deliver.
- **Communication, consistency and continuity, and comprehensiveness.** Most primary care professionals have not been trained specifically in how to communicate with young people – this needs to be addressed. Consistency and continuity mean providing a sustainable, consistent, continuous service that young people know is there when they need it and will continue to be there. And while specialist services will always be needed, primary care is also necessary to be able to offer a comprehensive service that allows the young person to have all of his or her physical, emotional, psychological and social issues considered.
- **Trust.** Young people say the key thing for them is to be able to trust the practitioner. This is not about having confidentiality statements or posters setting out the mission of the service – it is much more about trust on an interpersonal level between the young person and the practitioner.

Dr Churchill concluded by suggesting that efforts should be made to equip and resource universal and sustainable existing primary care services to meet the needs of young people, rather than investing in new "add-on" services that may not be sustainable.

Outcomes and discussions from this session are reflected in suggested action areas 24–27.

Trevor Gibbs, a principal in general practice from the United Kingdom who is consultant in primary care and family medicine to Ukraine, introduced a panel session on **experiences of various models of YFHS and quality improvement initiatives** by explaining that health statistics around the world do not differ greatly – the problems countries face are broadly similar. Participants were now being offered an opportunity to consider how best to address these problems, and how systems can be changed to make things better.

Participants heard six brief presentations, which are summarized below.

United Kingdom (Scotland) Scotland has a wide range of legislation and policy in place that impacts on

YFHS. These range from general policies which define the guiding principles underpinning health services in the country, to specific work aiming to develop YFHS. The former includes the drafting of a patients' rights bill which will pave the way for greater democratic accountability in Scotland's national health service (NHS) and enshrine patients' rights to access to services, dignity and respect, communication and information, and privacy and confidentiality. These rights will apply to all, including children and young people. Human rights requirements are also being addressed through the "Fair for all" approach which, in its attempts to support the NHS to engage with disadvantaged and disenfranchised groups, published age guidance for NHS boards in 2007 that identified a number of situations in which young people are discriminated against by the NHS. These include young people being placed in adult hospital wards, lack of age-appropriate information, and young people's confidentiality not being respected. The *Equally well* strategy (7) sets out how the country is tackling inequalities in health.

YFHS are being promoted through a range of policies in Scotland, including guidance on hospital facilities for young people to ensure their health, social and education needs are met. Significantly, the guidance recommends that the age limit for admission to children's hospitals be raised to 16 years. The "Walk the talk" initiative aims to develop youth-friendly practice in mainstream NHS services, including a seven-step guide to good practice. Health and well-being in schools is being pursued through the *Curriculum for excellence* (8), which recognizes and promotes the importance of health and well-being elements in learning settings, and health care capacity in schools is being promoted through the "Health and well-being in schools" project currently being trialled in four demonstration sites.

Ukraine Ukraine has witnessed a progressive deterioration in adolescent health status through the impact of socioeconomic factors, aggravated by the lack of resources in adolescent health care and lack of access to health care services for adolescent health. The country's "Reproductive health of the nation" initiative began to address these factors; under this, regional governments were ordered to open special centres for young people and integrate youth-friendly approaches into primary care. The first UNICEF-sponsored YFHS clinic opened in 1988, and there are now 53 such facilities in the country, 15 of which are supported by UNICEF. With the support of WHO and UNICEF, the Ministry of Health developed national standards on YFHS, based on WHO guidance. These provide the criteria for having YFHS status conferred, and a process of assessment of centres against the standards is currently under way, with plans to extend the standards and assessment to HIV clinics.

The former Yugoslav Republic of Macedonia Partnerships have been developed within the country to tackle issues in adolescent sexual and reproductive health (SRH). No specialized services existed prior to this for young people; service orientation was exclusively biomedical, and the policy and legislative framework for young people's health was fragmented and inconsistent. An SRH clinic especially for young people was opened by the Ministry of Health and the NGO Health Education and Research Association (HERA) in partnership with international organizations in 2005, followed by a second in 2006. These are based on the "I want to know" model originally used with Roma youth. The centres offer free and confidential sexual health services to young people, and have had a high uptake. They are not, however, part of government funding mechanisms and lack political support, and current trends towards privatization of the health care system in the country are discouraging of attempts to create youth-focused services in primary care settings.

Sweden The Swedish presentation focused on accessibility of male youth to Swedish health services. While Sweden now has over 200 YFHS in place, there are questions over whether they appear "friendly" to boys. More girls survive adolescence (three times as many boys as girls die each year in the country), and girls access health services more frequently and perform better academically. Fatalities in boys tend to arise as a result of preventable causes such as accidents, homicides, suicide and substance misuse. They are more likely to adopt unhealthy lifestyles and not access health services. Only 10% of boys access YFHS, mostly because their girlfriends take them. It could be that gender stereotypes which suggest that boys are "not meant" to care about health are at play here, or perhaps boys perceive YFHS as being tailored to girls' needs. More data are required on boys' needs, and potential solutions include greater efforts to engage with boys

in their own territories (sports fields, etc.), use of male peer educators and wider availability of boys-only sessions at clinics

Dundee, United Kingdom (Scotland) Two young volunteers from “The Corner” project in Dundee, Scotland gave a presentation on their experiences in the project. “The Corner” was created by a partnership involving Dundee City Council, NHS Tayside, the Scottish Government and young people. It is a health and information service for young people which provides a unique and integrated range of services through its high-profile city centre drop-in facility and outreach work in local communities. The volunteers described some of the activities they are involved in, which include contributing to the “Walk the talk” national resource (one of the aims of which is to raise awareness of barriers to young people accessing health services), delivering training to health service staff and providing information to peers.

EYF The EYF reported on a European survey they had conducted of 62 member organizations, including 20 national youth councils. The aim of the survey was to bring young people’s voices into the meeting. Survey results included the following.

- Just over 68% had YFHS in their country, of which 65% were considered “available” or “very available” and 72.7% were either “satisfactory” or “very satisfactory”.
- The key characteristics of YFHS were identified as: confidentiality; availability; location; staff knowledge of adolescent and youth issues; price; and friendliness of staff.
- Only 31.7% of countries reported that youth organizations and young people were consulted in the development of health policy.
- Almost 72% believed YFHS were either “not sufficiently” or “poorly” publicized in their countries.
- Almost 90% (89.7%) believed that using the Internet, social networking and other new media would contribute to enhancing the health of young people.
- The main health areas in which young people require specialist health services were identified as: SRH; drugs, alcohol and other addictions; and mental health.
- Just under 85% had SRH education in their country, although over half believed it was either “limited” or “not sufficient”; 82.4% was delivered through the formal education system.
- The biggest obstacles to effective SRH education included prejudices and taboos and lack of confidentiality; suggested solutions included integrating SRH into youth policy and starting sexual education earlier.

The EYF then presented a number of recommendations which have been reflected in the suggested action areas from the meeting.

Outcomes and discussions from this session are reflected in suggested action areas 7, 9, 14, 16, 21, 30 and 34.

Five tool-based workshops

The next session involved five simultaneous workshops which featured selected tools for the development, implementation and evaluation of policies and services for young people. Participants had a chance to subscribe to their preferred workshop prior to the meeting. The format consisted of brief presentations, which are summarized below, followed by general discussion, the main points from which are also presented below.

Workshop 1. Supporting policy development: summary

A. A guide for developing policies on the sexual and reproductive health and rights of young people: SAFE policy guide

The IPPF EN has been a lead advocate of young people’s sexual and reproductive health and rights over the years. Its member associations have piloted initiatives to provide sexuality education, information and services and promote a right-based approach towards the sexual and reproductive health and rights of young people.

The *Guide for developing policies on the sexual and reproductive health and rights of young people in Europe (9)* (also available in Russian) was created to inspire and assist policy-makers and governments in the creation and/or improvement of policies and programmes that respond successfully to the sexual and reproductive health and rights of young people. It identifies the main challenges to young people's sexual health and development and provides guidance based on evidence and good practice. The guide complements the *WHO European strategy for child and adolescent health and development (10)* and national strategies on sexual and reproductive health and rights of young people. A brief summary version is also available.

The guide takes a positive, comprehensive, rights-based approach to young people's sexual and reproductive health and rights and recognizes that while there are basic underlying principles that provide a common thread for policies, policy implementation will vary depending on national legislation and political settings, service structures and other national considerations.

The guide includes five sections on key policy areas: information, education and communication; access to YFS; contraception; STIs and HIV; and unwanted pregnancy and safe abortion. It also identifies crucial cross-cutting issues, including: youth participation in policy development; gender; protection policies; the importance of a multisectoral approach; effective monitoring and evaluation; and diversity and vulnerability. Ideas on how to work on challenges such as social exclusion, poverty, marginalized groups and migration are addressed in the guide. It has particular value for those who wish to promote strong advocacy messages to secure funding and political leadership for young people's sexual and reproductive health and rights, supporting them to develop the arguments they need to make progress in these areas.

The guide has been developed in partnership with young people, and IPPF EN is now reviewing the recommendations from the EYF survey to see how it can support further action. IPPF EN will be meeting with EYF to determine a joint way forward, particularly in relation to gender issues and sexual and reproductive rights, and will also be working with other stakeholders in developing its advocacy and political role.

B. Using human rights to advance sexual and reproductive health of youth and adolescents: a tool for examining laws, regulations and policies

Many countries have made great strides in improving availability of, and access to, sexual and reproductive services for adolescents and young people. However, without a supportive and protective legal and policy framework, many adolescents and young people are denied access to such services due to their marital, social or other status. Furthermore, gaps in laws and regulations, discrepancies between laws and/or policies, insufficient knowledge among health providers of existing laws and regulations and inadequate enforcement mechanisms further impact on the effective provision of services.

In response to these challenges, WHO has developed a comprehensive toolkit to assist ministries of health and partners in conducting rights-based adolescent sexual and reproductive health law and policy assessments. The tool assists countries in using a human rights framework to identify and address legal, regulatory and policy barriers to adolescents' access to, and use of, sexual and reproductive health care information and services and to the provision of quality services. It also identifies particularly vulnerable groups and examines governments' efforts to meet their needs.

The toolkit facilitates a very systematic application of human rights principles (such as non-discrimination, participation and accountability) to policies and programmes. It also enables a very thorough examination of relevant laws, regulations and policies to ensure they are supportive of, rather than a barrier to, adolescent sexual and reproductive health, and that they comply with international standards.

The toolkit promotes increased multisectoral collaboration and enhanced stakeholder awareness of the value of applying a human rights framework to adolescent sexual and reproductive health law and policy

development. It is a complex package which may take 10–12 months to apply and which requires sustained health ministry ownership and leadership. Application is effected through four phases: securing leadership commitment; identifying local researchers with expertise in public health, SRH and adolescent health, and in legal analysis; establishing a national project team of key stakeholders (including young people) led by the health ministry to implement the toolkit nationally and compile and analyse data; and reporting findings and preparing a plan of action. The toolkit is being field-tested in Tajikistan and Sri Lanka.

C. Action tool of the *WHO European strategy for child and adolescent health and development*

The *WHO European strategy for child and adolescent health and development (10)* was developed to support Member States of the European Region to develop and review their own child and adolescent health strategies. It defines health priorities for children and adolescents in the region and its action tool presents a “menu” of evidence-based interventions in these areas.

WHO has recently commissioned the review of the “adolescent part” of the strategy’s action tool. Evidence in areas such as obesity, violence, adolescent pregnancy, injury and substance misuse has been identified to support effective interventions at policy, services, family and community levels. The review also looked across sectors, as it was recognized that the contribution of non-health sectors to promoting adolescent health could be greater.

The mental health section was demonstrated as an example. It defines the priority (such as “mental health and health promotion, including self-harm and suicide prevention”), then makes suggestions for cross-sectoral evidence-based interventions in various areas: health in all policies; schools setting; family and community level; health system; and health services. The evidence sources to support the interventions are cited, although the strength of the evidence varies. The same “template” is used for other identified priority areas, such as overweight and obesity.

Countries can use the tool to critically review their existing practices in these priority areas, identifying gaps in policy or service provision by area and by level. The interventions can also be reviewed by category – a school nurse reviewing her practice against the “school setting” column across the priority areas, for example.

D. Gender tool of the *WHO European strategy for child and adolescent health and development*

There is growing evidence to show that actions to improve the health of adolescents need to look into gender differences in vulnerabilities, protective and risk behaviours, health outcomes and access to services. These gender differences may be determined by inequalities in society and by different gender norms and values.

The original gender tool focuses on advocacy to raise awareness about the relevance of gender issues to child and adolescent health, moving away from an exclusive focus on SRH to identifying gender issues across all priority health areas. In mental health, for instance, it is recognized that suicide rates for boys are much higher than for girls, while eating disorders are more common among girls. Boys are much more likely to be involved in violent incidents and to sustain injuries, while girls are more likely to feel they are “too fat” and have a negative self-image. Findings like these are very much national context-related, but nevertheless occur throughout the European Region and across social gradients. It is vital that they are considered in policy development and implementation.

The tool has been used in countries such as Tajikistan and Albania as part of the process of developing a national child and adolescent health strategy. Results have varied: while no one denies the importance of gender to child and adolescent health and the importance of having gender-responsive services, translating that recognition into action is difficult. And even if there is no legal gender discrimination in a country, gender biases are often evident at health service provider level.

The challenge is how to make the tool practical. One way of doing it, envisaged by WHO, is to integrate gender-responsive actions into the action tool; work on this is currently under way with the “adolescent

health” part of the tool.

Main points from Workshop 1

- As important as the evidence base, design, development and piloting of the tools may be, the process of implementation is even more important. Without solid structures to support implementation processes in countries, tool development becomes an academic exercise.
- The implementation process is most positive when it is country-led; WHO can provide support and technical expertise, but countries need to lead the process to ensure that it results in changes in policy and practice.
- Ministries of health are in powerful positions to lead on behalf of their countries and have a clear stewardship role in tool development and implementation.
- Tools for policy development are most effective when they are developed alongside complementary action tools which support practical application.
- Costing and financing of tools are important issues for countries.

Workshop 2. Measuring quality of services: summary

A.WHO national standards development/quality measurement/coverage measurement tools

The “Making health services adolescent friendly: developing national quality standards for adolescent-friendly health services” tool is intended to guide the development of national quality standards for health service provision to adolescents. National reproductive health and HIV programme managers would oversee the development of the national quality standards through a consultative decision-making process. The process itself would need to be facilitated by an individual who has been introduced to the tool and has been involved in applying it in at least one setting. The tool is currently being edited and laid out and will shortly be available on the WHO child and adolescent health web site (in English, with other language versions to follow).

The quality assessment guidebook, “A guide to assessing health services for adolescent clients”, is intended to enable programme managers to assess the quality of health service provision for adolescents and to take appropriate action where the quality is found to be wanting. The guidebook will require adaptation for country-level use by an individual with expertise in measurement. Once adapted, it will be used by health facility managers, district health management teams and national reproductive health and HIV programme managers. It is in press and will shortly be available on the WHO child and adolescent health web site (in English, with other language versions to follow).

The “Tool to assess the coverage of health service provision to adolescents” aims to enable programme managers to assess coverage and take appropriate action where the coverage is low. It can be used by individuals with expertise in measurement in conjunction with national- and district-level HIV and reproductive health programme managers. A draft tool has been developed and tested, and is currently being revised.

B. *You’re welcome* quality criteria: improving acceptability, accessibility and appropriateness of health services

You’re welcome (II) is a countrywide programme designed to improve the quality and responsiveness of health services to better meet the needs of teenagers in the United Kingdom (England). The *You’re welcome* quality criteria set out principles that will help health services (in the community and hospitals) to become young people friendly. The criteria are designed to include all health services, covering general and acute health problems, chronic and long-term disease management (such as specialist diabetes care) and health promotion. The 10 themes are: access; publicity; confidentiality, competence and consent; environment; staff training, skills, attitudes and values; joined-up working; involvement of young people, monitoring and evaluation; health issues for young people; sexual and reproductive health services; and child and adolescent mental health services. The criteria are based on examples of effective practice and are underpinned by the

ethos that all young people are entitled to receive appropriate health care wherever they receive it.

To help local areas apply *You're welcome* consistently, the Department of Health has put in place a national implementation support network. Links have been made with the drive to raise quality and improve performance across the NHS.

C. Provide: strengthening youth-friendly services

The IPPF *Provide: strengthening youth friendly services* toolkit (12) is a self-assessment guide to increasing young people's access to a broad range of youth-friendly services. The tool is intended to support IPPF member associations and other organizations striving to expand and improve the quality of their youth-friendly services and encourages the empowerment of young people to participate in the process of ensuring high-quality services. It allows for reflection on existing programmes with a view to improving their quality by encouraging critical thinking on crucial questions, such as: "what does quality mean?"; "what is an ideal service?"; and "what makes a sexual and reproductive health service accessible and acceptable to young people?". The tool takes a rights-based approach to service delivery and is based on a comprehensive understanding of what young people want, rather than on what providers believe they need. It therefore promotes the fundamental condition that services must respect young people's life choices. The tool sets out minimum standards for adolescent services which take into account gender sensitivity, rights and the community, and can contribute to high-quality youth-friendly service provision.

Main points from Workshop 2

- Quality standards and criteria are most relevant when based on identified key issues on adolescent sexual and reproductive health and youth-friendly services at country level.
- Quality-of-care tools work best when they are "user-friendly", are positive and do not jeopardize the work of service providers.
- Youth-friendly services need support in adopting self-assessment practices regularly, and young people need encouragement to participate in the self-assessment process.
- Young people have a very important part to play in adapting quality assessment tools and monitoring youth-friendly services. Participation of young people should be consistent with a clear description of roles. Information technology (IT) can help to facilitate youth participation in monitoring of service quality.
- Benefits can be gained from approaching the health of young people from a multidisciplinary, and not purely biomedical, perspective.
- Benefits can be gained from countries developing: mechanisms and systems to integrate knowledge and experience of youth-friendly services into the broader context of national policies focused on youth; the prevention role of youth-friendly services; and mechanisms to ensure that quality youth-friendly services are provided to young people free of charge.

Workshop 3. Overview "masterclass" on youth-friendly services: summary

A. WHO orientation programme on adolescent health for health care providers

The programme aims to orientate health service providers (doctors, nurses and clinical officers) to the special characteristics of adolescents and to strengthen their ability to carry out two key functions: responding to the special needs of their adolescent patients; and being an advocate and change agent on their behalf in their communities. It defines what health service providers need to know and do differently if the patient they are dealing with is an adolescent, not a child or an adult, and how they can help influential people in the community to understand and respond to the needs of adolescents.

The programme has been published in English, French and Russian and is currently being translated into Spanish.

B. Tool to adapt the generic WHO "Adolescent job aid"

This tool is intended to guide the national adaptation of the generic WHO “Adolescent job aid”, a desk reference to assist primary-level health workers to manage common adolescent health and development issues, and to guide discussion and decision-making on how it can be applied to complement the teaching and learning materials that are available and in use in countries. It is intended for people trained in the use of the tool and who have supported its application in at least one setting. They will need to work with national authorities responsible for building health workers’ capacity to respond to adolescents. It has been finalized and is currently being prepared for publication.

C. Pedagogic methodologies used by the European Training in Effective Adolescent Care and Health (EuTEACH) programme

EuTEACH provides a training curriculum with detailed objectives, practical strategies and resources for trainers and teachers in the field of adolescent health. It is freely available on the Internet (www.euteach.com) and helps health care professionals to set up appropriate training sessions for those involved in adolescent health: clinicians, professionals involved in prevention and health promotion, public health officers and policy-makers.

EuTEACH involves: identifying training needs; examining outlines of teaching modules already available; planning, running and evaluating sessions; and enabling access to basic references and information on adolescent health and medicine and to resources specific to the module’s topic.

D. Motivational interviewing with adolescents: an effective tool to improve the adolescent lifestyle or reduce risk-taking behaviour

The concept of motivational interviewing (MI) was originally developed to assist professionals in the care of individuals with substance misuse or dependence problems (13). It advocates a non-judgemental, neutral approach to the care of patients who, at the beginning of the process, are often unwilling to accept the intervention of the professional. MI is a blending of techniques from existing approaches, with a focus on stages of change. Patients are encouraged to explore the advantages and disadvantages of their behaviours and what would make them change or not. They are supported in exploring their ambivalence; the health care providers “roll” with the resistance of the patient and adopt a supportive, non-judgemental tone. The patient is consequently progressively led to make commitments and foresee behaviour modifications.

Adolescents are sensitive to empathetic professionals who attempt to construct a discussion with them, so they feel comfortable talking about their problematic behaviour. In doing so, professionals maintain or even improve the adolescent’s search for autonomy. The adolescent makes the decisions, not the health professional.

While there are currently hundreds of evidence-based studies showing the effectiveness of MI interventions among adults, the number of research studies conducted among adolescents is less impressive. However, there is evidence that MI works with young people in areas such as eating disorders and substance misuse (14). Some basic MI tools can be acquired with 2–3 days’ training and can be applied by any health care provider dealing with young people.

As adolescents engaging in problematic behaviours often resist the intervention of professionals, MI represents a promising approach to overcoming the resistance of young patients. The staff of adolescent-friendly services should be encouraged to acquire the basic skills of MI.

Main points from Workshop 3

- The quality of child and adolescent services will be promoted through provision of, and support for, professional training and education for staff. The EuTEACH web site offers a sound vehicle for professional development.
- More training in, and application of, motivational interviewing techniques could prove beneficial in changing adolescents’ health behaviours.

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- Ministries of health could be supported by WHO to develop packages for working with other ministries on issues that affect adolescent health and to prepare cases for advocating for adolescent health services with governments.

Workshop 4. Sexuality and relationship education: summary

A. Drafting standards for sexuality education in Europe - a European work in process

The standards for sexuality education are being developed by the WHO collaborating centre for sexual and reproductive health at the Bundeszentrale für gesundheitliche Aufklärung (BZgA) [Federal Centre for Health Education], Germany. The process was initiated by the WHO Regional Office in 2008 and is supported by a group of more than 20 experts from 8 European countries. The intention is to support the development of comprehensive sexuality education in Europe. The focus of the standards is not only on helping young people to protect themselves from negative effects related to sexuality, but also to empower them to determine their own sexuality in a positive way. The core of the tool is the definition of topics, which are essential in comprehensive sexuality education in relation to the developmental needs of children and young people. The standards will therefore offer valuable support to developing curricula for sexuality education in Europe.

B. SHARE (Sexual Health and Relationships Education): a working, evidence-based example from United Kingdom (Scotland)

SHARE is a curriculum resource for professionals working with young people in secondary school years 2–4 (13–15-year-olds). It offers a comprehensive, evidence-informed overview of sexual health and relationships education and addresses the complexities that surround this subject. SHARE has been fully supported by a national training programme over the last five years and many regional and local events, which have resulted in a strong and committed workforce. “Relationships, sexual health and parenthood” is an important topic that is embedded within the “Health and well-being” aspects of *Curriculum for excellence* (8); SHARE fully supports implementation of this new curricular area.

C. Youth peer-education standards

Standards for peer-education programmes (15) is a manual produced in partnership by UNFPA, the Youth Peer Education Network (Y-PEER) and Family Health International/YouthNet that aims to support programme managers to standardize practice in peer-education programmes. It includes a checklist of 52 standards in five categories: planning; recruitment and retention; training and supervision; management and oversight; and monitoring and evaluation. It offers tips, lessons learnt and other information on each of the 52 standards. A four-page version is also available for managers to take with them on site visits.

The manual is part of the bigger “Youth peer-education toolkit”, a group of resources designed to help programme managers and trainers of peer educators. Collectively, these tools should help develop and maintain more effective peer-education programmes. All parts of the toolkit are based on research and evidence from the field and provide local examples and experiences. They are designed to be adapted locally as needed.

Main points from Workshop 4

- Careful consideration is needed to identify what kind of sexual education children aged 0–9 years need. This group is more sensitive to such themes and their needs differ from teenage groups. Special educational programmes are needed for children of this age, taking into consideration their psychological and emotional status, and recognizing the need to adjust information appropriately.
- It is important to involve parents in the sexual education of children aged 0–9 years, and religious concerns should be addressed.
- There may be an important role for WHO in helping to “translate” the idea of standards for sexuality education to Member States and advocating for their implementation.

- The proposed standards for sexuality education in Europe should set minimum standards and should be capable of being adapted to countries' particular needs and situations. They should also be tested among different groups.
- Promotion of the standards would be most productive if started in schools, where many children can be reached.
- The SHARE programme from United Kingdom (Scotland) offers a positive example that other Member States may wish to explore and emulate. It would be necessary to perform a comparative study, however, before scaling-up the experience among Member States.
- It is recognized that school curricula tend to be “crammed”, but significant benefits can accrue for children and young people when innovative approaches are taken to creating time to focus on sexual education within the school curriculum.
- There is clear evidence that peer education is a powerful methodology for sexual education among young people. It is important to identify opportunities within primary health care and youth-friendly services, including school health services, to adopt peer-education approaches.
- Standards for peer education are most effective when adapted to country needs and approved nationally, possibly to accreditation level.
- There may be benefits in scaling-up the peer-education methodology for work within clinical facilities and to explore possibilities within national HIV-prevention programmes.

Workshop 5. Use of technology for professional education and engaging youth: summary

A. E-learning in adolescent health – the United Kingdom experience

A wide range of health professionals in the United Kingdom encounter young people in the course of their day-to-day clinical work, but few have received any specific training in adolescent health care. In response to this need, the Department of Health in England funded a project to develop an e-learning package in adolescent health. The project was a partnership involving a number of organizations, including E-Learning for Healthcare, the Royal College of Paediatrics and Child Health and other professional royal colleges.

The “Adolescent health project” consists of over 70 focused e-learning sessions written by specialists from a range of disciplines. The sessions are each intended to take 20–30 minutes to complete and are set at four different levels of complexity to meet the educational needs of different groups of professionals. Content is based on needs analysis and by matching the curricula competency requirements of all doctors and nurses. The highly interactive materials have been designed to be used on a standard laptop or personal computer via a broadband Internet connection at home or in the work place. The content includes high-resolution images and video clips to enrich the learning experience and increase visual accessibility. The package is currently being disseminated across the NHS.

B. Training with simulated patients

Skills in psychosocial communication with adolescents differ from those required for younger patients and adults, because they include discussing issues such as confidentiality and adolescent risk-taking behaviours. The use of adolescent simulated patients is a technique that gives the opportunity to the learner (medical students, physicians in training and other health professionals) to be trained in real-life situations in a safe environment. At the end of their “performance”, the learners can receive direct feedback from the adolescent simulated patient.

C. “Cool2talk”: use of technology for professional education and engaging youth

The “Cool2talk” web site is a successful and economical way of reaching young people in the context of other local service provision. “Cool2talk” is an interactive web site through which young people in the region of Tayside, United Kingdom (Scotland) can have their health-related questions answered honestly and accurately. It offers reassurance, encouragement, information and advice on any health-related issue and signposts young people to appropriate services. Its target audience is young people aged 12–18 years.

The questions provide a resource for young people's workers to get an idea of the current issues that concern young people, as well as a means to evaluate the site. Young people can post a question onto the site and get an answer within 24 hours. When accessing the site, they will be asked to supply quantifiable data such as age, gender and the first part of their home postcode. An overall view of the use of the site can emerge through these data.

The number of questions received varies with the promotion of the site. Promotional packs are available for young people's workers and teaching staff and promotional events take place across Tayside, with "Cool2talk" workers available to answer young people's questions.

Main points from Workshop 5

- E-learning opportunities show great promise in enabling health care professionals working with young people to meet professional curricular requirements and improve the health of young people.
- Enrolment of currently practising practitioners to e-learning programmes can be encouraged through linking the programmes to web sites frequently used by health care professionals.
- The e-learning package in adolescent health in the United Kingdom would have greater perceived value if it had a certification scheme of accreditation.
- Initiatives like the "Cool2talk" programme could produce benefits if rolled out nationally while maintaining a local focus (which is considered vital to the success of the programme). The programme could be promoted nationally as a support and educational tool not only for young people, but also for health care professionals.
- Greater support for programmes like "Cool2talk" would be likely to arise if an evaluation and audit of the programme was carried out to, for instance, measure the impact of the advice given and to assess the number of users who seek out recommended services.
- Any increases in the demand for a service would, in all probability, lead to requirements for greater funding and more staff. Such extra resource would, however, enable the service to develop initiatives such as a real-time chat service and to increase the number of service users through developing and promoting the outreach elements of the service.
- As with all such initiatives, young people have an important role to play in service development, feedback and evaluation.

Outcomes and discussions from the workshops are reflected in suggested action areas 6, 20, 31, 33 and 35.

Spotlight session

Youth-friendly services – are we reaching adolescents most at risk?

The session was opened by **Nina Ferencic, UNICEF Regional Office for Eastern Europe and Central Asia**, who defined most-at-risk adolescents (MARA) as those who are vulnerable due to the circumstances they find themselves in – for example, homeless or institutionalized children, those working in the sex industry, or those coming from disadvantaged communities, such as Roma. Many of these children exist outside the mainstream social, education and health sectors.

Dr Ferencic explained that eastern Europe has gone through a tremendous process of transition in recent years, which is affecting more than 300 million people. Young people have suffered much in terms of rising unemployment, high rates of institutionalization and the rising phenomenon of "social orphans" (where parents abandon their parental rights, due mostly to economic hardship). There is endemic substance misuse and suicides (8 of the top 10 suicide rates in the world are in countries in this region) and an HIV epidemic; 1.7 million people are living with HIV (a 20-fold increase in the last 20 years) and one third of new infections involve 15–24-year-olds. A study carried out in St Petersburg, Russian Federation, in 2007 showed that almost 40% of street children aged 15–19 were HIV infected. Ninety-seven per cent of these young people were also sexually active, 65% of them with multiple partners, leading to a complex picture of risk behaviour.

The HIV epidemic reflects, among other things, the significant problem of injecting drug use among young people, with an estimated 2 million injecting drug users in the countries of the Commonwealth of Independent States and 300 000 in central Asia.

The risk behaviours being seen often begin in adolescence. Dr Ferencic reported on an as-yet unpublished study carried out by UNICEF and the London School of Hygiene and Tropical Medicine which shows the early age of initiation of injecting drug use in the region: in Ukraine, for example, 45% of drug users commence injecting before the age of 15 years, and almost all of them are injecting before the age of 18.

The “pathways of risk” for MARA lead from families, communities and systems, Dr Ferencic suggested. Families are in economic and social crisis, often leading to children being left without parental supervision as parents move to find work elsewhere. Communities are increasingly facing the problems of high levels of unemployment. And systems, such as education and health, are finding it difficult to meet the needs of young people. To escape the harsh realities of their lives, many children turn to drugs and other substances, and services, which are designed for adults, are not reaching them.

The controversial mix of drugs, sex and minors that MARA represent, Dr Ferencic said, is a mix that no politician wants to touch. In addition, there is very little reliable data on these young people, a huge amount of stigma and discrimination associated with them, parental disengagement and community, social and religious opposition to attempts to develop services for MARA, who many see as “lost causes”. There are also service provision barriers such as legal barriers to access to services without parental consent and necessary documentation, payment and location barriers, and service prejudice towards MARA; these help to make the young people distrustful of services. Those services that do want to help find barriers that stop them from doing so (like a requirement to report drug users to the police). Even NGOs are proving reticent to get involved for fear of being seen as exploitative of MARA.

UNICEF is now working with partners to get MARA on the agenda and to acquire the evidence needed to inform meaningful interventions, Dr Ferencic explained. It is trying to build political and community support and to remove barriers to use of services by MARA.

Dr Ferencic’s colleague, **Olena Sakovych, UNICEF Country Office, Ukraine**, then provided an example of how youth-friendly services in Ukraine are trying to reach out to MARA. She described MARA as “the missing face of the health and community response”, in that so little is known about them, few service providers are interested, and there is no strategy to meet their needs. Research carried out by UNICEF, however, has uncovered some key facts, such as: MARAs’ high levels of HIV-risk behaviour and overlapping risks, which are higher than among their older counterparts; significant service access barriers faced by MARA, with very low service-seeking behaviour and few referrals; and serious concerns about the sexual and reproductive health of MARA girls.

Ukraine now has in place a network of youth-friendly clinics supported by a legislative framework, service standards and certification, in-service and postgraduate training for professionals, strong quality assurance mechanisms, links with social services and youth participation. These youth-friendly clinics now face the challenges of becoming MARA-friendly, reaching and protecting MARA, building the capacity of service providers and overcoming the legal barriers and stigma that stop MARA accessing services. Despite these challenges, youth-friendly clinics provide an emerging opportunity to reach MARA which should not be missed, Ms Sakovych said.

Neil Hunt, Director of Research for KCA(UK), a treatment agency in the United Kingdom, described the youth-friendly ethos that has been developed within the agency as a means of engaging with and encouraging participation from young people who have drug and/or alcohol problems. The agency has a young workforce (most are aged from 20 to early 30s) who are able to talk to young people in a language they understand and share many cultural reference points with young people. Many have experience of drug use within their friendship and family networks and may have personal experience.

The workforce emerges from a range of disciplines, including teaching, youth work, social work and nursing. They are professional, well-informed and able to work equally well with young people who are at different stages of their drug or alcohol use. They work with young people on their terms (stopping drug use is not assumed or required, Mr Hunt explained, but is always considered) and use a range of age-appropriate tools and resources, many of which were developed within KCA by young people. Meetings with young people are arranged when it suits them (perhaps lunch time or after school) and where it suits them (school, cafes, parks etc.).

Mr Hunt explained that parents are involved whenever possible and appropriate, with the young person involved in the decision about how and what they are told. In this way, the KCA worker doesn't direct the work: it is directed in a partnership involving the practitioner and the young person. It is always carefully explained, however, that the agency's youth-friendly ethos does NOT override its professional and legal obligations. Obligations to, for instance, share information with youth justice systems and comply with child protection legislation have to be met within the framework of the youth-friendly service.

Mr Hunt drew some contrasts with the situation in the United Kingdom and some countries in eastern Europe that he has worked in. He explained that there are more resources in the United Kingdom for young people's services, and strategic leadership has not been developed to the same extent in eastern Europe. Particularly striking is the dominance of the medical profession and medical model in drug and alcohol treatment programmes in eastern European, which contrasts very starkly with service provision models in the United Kingdom, in which medical involvement is the exception rather than the rule. There are also significant differences in the target groups for drug and alcohol services. While the United Kingdom does have street children who misuse drugs and alcohol, it is clearly of a different order of magnitude than some eastern European countries; there is a Roma community in the area in which Mr Hunt provides services, and it is largely integrated into education, health and social systems.

To conclude, Mr Hunt said that youth-friendly services require strong strategic leadership and resources, a robust commitment to youth-friendly services and a willingness among staff and partners to work in different and innovative ways.

In closing the session, **Rita Khazayeva, Programme Technical Adviser on Health and Rights in the UNFPA Regional Office of Eastern Europe and Central Asia**, summarized that:

- dealing with MARA requires policy commitment to address the issue, rather than “turning a blind eye”;
- health systems have a great responsibility in the process and are critical components in dealing with the health and social care needs of MARA – there are roles for primary care, for general practice and family doctors, and for youth-oriented and specialist services;
- early interventions are important;
- age-appropriate tools have a role to play, especially in helping to engage MARA in conversations and identifying opportunities for effective interventions;
- a knowledgeable and experienced workforce with ongoing training opportunities is needed, as the risks MARA face keep changing;
- young people should be able to direct the service; and
- linkages and referrals between health, social, education and child protection services are critical.

The crucial questions that need to be asked of youth-friendly services, Dr Khazayeva suggested, are the following.

- Could MARA use the services if they wanted to?
- Are the services appropriate and accessible?
- Are they effective – will they make a difference to MARA?

- Are they being developed with the needs of MARA, and not just children and young people in the mainstream, in mind?

Outcomes and discussions from this session are reflected in suggested action areas 4, 13, 18, 28 and 32.

Meeting day 3

Health care at school: pairing young people with health services

Day 3 was opened by the chair, **Olivier Duperrex, Medical Head for School Services for Canton de Vaude, Switzerland**. Dr Duperrex described how the geographically short distance of 80 km involved in moving job from Geneva to Lausanne also involved a very large move in culture for him. In his former work, he explained, the school health service (SHS) was based within the education system, while in his new area, it is based in a joint structure involving the education and health departments. Regardless of the particular culture in which SHS are based, however, professionals in SHS have to define a *subculture* of school health, he said.

Miriam Levi, WHO temporary adviser, then reported on a WHO survey of the organization of SHS in the WHO European Region. Dr Levi reported that the survey was designed to:

- generate evidence about SHS' contribution to priority health and development needs of pupils in Member States;
- define SHS content and orientation towards health promotion;
- identify health system aspects of ongoing reforms in SHS; and
- identify the need for revision of SHS scope and content.

Respondents were government chief nurses and national focal points for child and adolescent health and/or school health care in the country. The questionnaire was designed in a health system framework, looking at issues of service delivery models, financing, human resources capacity and governance. Responses were received from 33 countries.

Results indicated a general lack of funding, insufficient orientation towards health promotion, a mismatch between priority health problems and services provided, and school health personnel being insufficiently trained to provide appropriate services. The main challenges to SHS were identified as:

- lack of adequate funding (79% of respondents);
- insufficient involvement of families, teachers and communities in health promotion (71%);
- shortage of (65%), and inadequate training of (50%), SHS personnel;
- uneven SHS provision within countries (35%); and
- inequalities in access (29%).

Respondents identified important roles for WHO in supporting Member States to strengthen SHS, including developing guidelines and facilitating the sharing of experience among countries. WHO also had an identified role in advocating for SHS with national authorities. Dr Levi concluded by saying the survey had revealed a big gap between what *is* provided and what *should be* provided in the field of health promotion, and a general lack of funding for SHS. Decision-makers have to be made aware of this, she commented, as, to quote UNESCO, “investing in school health is investing in a country's future”.

Sven Bremberg, Director of the Department of Child and Adolescent Health and Mental Health at the Swedish National Institute of Public Health, then described current trends in the Swedish SHS. He explained that SHS in Sweden are evolving and are moving in the direction of being based on evidence. National guidelines have been produced, but SHS are funded by local municipalities which are autonomous, so can choose not to implement the guidelines.

The service is effectively completely staffed by school nurses, who are trained for three years in public health nursing, Dr Bremberg explained. There are 13 school nurses per 10 000 pupils, compared to one physician; this is a higher ratio than is found in any other country. Their main tasks are health promotion, health examinations, open consultations, supporting pupils with disabilities and immunizations. The current trend is to focus more on health promotion and less on health examinations, for which there is little supporting evidence.

Health promotion activities include individual consultations, classroom teaching on health issues and supporting the school as a learning environment. The evidence for focusing individual counselling on student-centred issues rather than subject-centred is clear, Dr Bremberg claimed, although subject-centred counselling may work with younger pupils. Motivational interviewing based on the stages of change model and Bandura's self-efficacy model offer suitable approaches which build on pupils' strengths. Cognitive-based programmes that can be administered by nurses and do not require the services of a psychologist are also helpful in supporting pupils to acquire the necessary skills to handle mental health problems. Approaches such as these are now being delivered via the Internet with school nurse support, Dr Bremberg commented.

Evidence suggests that classroom health education has some short-term benefits, but needs to be offered for at least two years. Attention is therefore turning to school-wide approaches, moving from specific methods to the core education objectives of the school. The Swedish National Institute of Public Health promotes a number of interventions that have proven efficacy, including social and emotional training, measures to prevent bullying and aggression, programmes based on cognitive psychology and local quality assurance programmes using both educational and health data to focus on health and achievement. SHS are now collecting data on individual students from health examinations and interviews and to aggregate data at class and school level, so they can feed back to school committees to influence the school environment.

Outcomes and discussions from this session are reflected in suggested action area 22.

Countries' examples in aligning school health services with pupils' needs

A panel discussion, chaired by **Vivian Barnekow, Division of Country Health Systems, WHO Regional Office for Europe**, was then held on the topic of countries' examples in aligning SHS with pupils' needs. Presentations were made from three countries and an organization before a wider discussion was held.

Denmark Several laws on SHS in Denmark were enshrined in a single piece of legislation in 1995. This legislation made children, rather than institutions, the main focus and was inspired by the *Convention on the Rights of the Child (1)*. Following a further review in 2007, the focus has very much been on health promotion and health "dialogues", with the scope for screening more limited than was previously the case. The SHS is now comprehensive, covering pre-school to post-secondary years, and has the aim of protecting and promoting children's and young people's health and well-being.

In a further review of services in 2009, it was decided that the physical examinations carried out as the child enters school and as he or she leaves can be performed by the school nurse. In the intervening years, the school nurse invites pupils to take part in health "dialogues" which focus on health promotion, the key element of the service. Pupils are considered active participants in health promotion, not recipients of health information.

Municipalities have an obligation to initiate multidisciplinary school counselling groups which focus on children with health and social concerns who are not in daily contact with the SHS. A named professional from the group assumes responsibility, seeking advice from others when necessary and keeping the general practitioner informed. The changes to the SHS have not yet been evaluated, but research on the values and norms of school nurses is being carried out.

The Republic of Moldova SHS in the Republic of Moldova have gone through three stages:

- organized health provision for each child with a school doctor and nurse for each school;
- reform of SHS to a nurse-only service focusing on physical examinations, referrals and the production of reports on prevalent disorders, with a family doctor looking after the schools in a defined area; and
- the introduction of compulsory health insurance, with no special financing for school health professionals and services continuing to be provided by the nurse and family doctor; the problem is that not all villages have access to a family doctor, so the SHS is provided only by a nurse.

The Ministry of Health set up an expert group, including insurance specialists, who examined the list of SHS detailed in health insurance policies for family doctors against those considered desirable for a SHS. Gaps were found, after which the ministry approached the government to amend health law and create a list of “additional health services provided in education institutions”. With help from WHO, a list of additional services was composed in 2008, with “family and community involvement” and “creating a supportive environment” being among the elements of service added.

Problems remain, in that the new list has still not been completely implemented in all schools, the quality of medical services available very much depends on the location of the school, and no universal monitoring or quality assurance system exists. Next steps include capacity building of providers involved in SHS provision, developing quality assurance policy and instruments and creating methods of increasing dialogue with civil society. A national mechanism of referral to specialist medical services and community services is also required. However, progress is being seen with the development of youth-friendly centres and other new services, although access is still not universal.

United Kingdom (England) *21st century schools (16)*, published in June 2009, sets out the right of every child in England to attend a healthy school. This will be enshrined in law in coming months. From 2011, Her Majesty’s Inspectorate of Education, which is responsible for inspecting schools, will be accessing schools’ contribution to children’s health and well-being and partnership working with health services, as well as educational outcomes. The data consequently generated will help in targeting needs effectively. Personal, social and health education will also be statutory parts of the school curriculum from 2011.

The “Healthy schools” programme has been running in England for the last 10 years. This is a health promotion programme that is currently voluntary, but 95% of schools have signed up. It is based on a participatory model that promotes engagement with children, families and communities. It is recognized, however, that SHS can be improved by making sure there are accessible services in the school setting that are based on local needs, data and evaluations. A healthy child programme (0–19 years) will be published in autumn 2009 which will set out what schools should put in place for children, including a school health team with a nurse at its centre, but with access to many more services.

While it is difficult to precisely identify the benefits of a health promoting school due to the variables that apply, there are indications that the health promoting school approach is having positive effects. The strong belief is that with the education system and health system working together, anything is possible.

Schools for Health in Europe (SHE) SHE succeeded the European Network of Health Promoting Schools (ENHPS) in 2007 and now has coordinators in 43 countries in the European Region. SHE believes that the right of children to go to a health promoting school is as important as the right of the child to education and security. Health helps to create better schools with better educational outcomes and higher job satisfaction among staff, and schools function better when health is introduced in a systematic way. But schools are not part of the health service, so the health sector cannot “tell” them what to do in relation to health. Health promoting schools are about immersing health, well-being and social capital throughout the school, having an impact on all pupils and staff. This “whole-school” approach is important, as it means that health

becomes part of the fabric of the school and is not just something taught in class.

SHE hosted the third European conference on school health promotion earlier in 2009, and from this emerged the Vilnius Resolution (17). This is a new tool to make a case for health promoting schools. The resolution opens with a declaration from children aged 14–16 who worked parallel to the adult conference and produced their own text. The main point they emphasized was that they want to be educated in health promoting schools. The resolution also states clearly what schools need to do to be health promoting, and what governments need to do to support them.

SHE believes the SHS is a fantastic asset for a health promoting approach, but that thought needs to be put into creating a new role for SHS; this should focus on how to support the process of change throughout the school. This calls for a different skills set, particularly for school nurses, who are the prime access point for children to SHS. Going forward, SHE will be pressing for more and better contact between SHE national coordinators and SHS, and for more training and capacity building for doctors and nurses.

There then followed a **discussion with the panel**, the main message from which was that services for adolescents and young people are more effective when SHS, health promoting schools initiatives and youth-friendly health services are interlinked.

Outcomes and discussions from this session are reflected in suggested action area 29.

Human resources for adolescent health

The final plenary session of the meeting prior to the development of suggested actions was started by **Susanne Stronski** of the **European Union for School and University Health and Medicine (EUSUHM)**. Dr Stronski described an analysis of SHS in 11 Member States of the European Region that took place at a joint meeting with the International Association of Adolescent Health in 2008.

The analysis showed that a variety of ways of organizing the services was being employed across the countries, and that organization was weak in some countries. With the exception of one country (Slovenia) which offered both preventive and curative services, SHS were exclusively preventive in focus. Those that were publicly funded either did so through health insurance or national, regional or local financing mechanisms, and private funders included churches and foundations. A wide range of medical and non-medical health staff offered SHS services and there was huge variety in the training they received, ranging from a fully recognized specialty of school medicine, to short courses, to nothing.

In summary, the survey found a lack of: definitions of competencies, quality standards and evaluation mechanisms for training; interest and motivation among providers about training in adolescent and school health; finance for training; awareness among authorities of the importance of adolescent health (and therefore for the need for training); support from the medical system; and a systematic approach.

Dr Stronski concluded by recommending that there should be:

- a definition of minimal competencies for professionals in adolescent and school health, including specific recommendations on the training and capacities of school nurses;
- a European standard for professional training in adolescent and school health, with complementary evaluation tools and quality indicators leading to the recognition of a (sub)specialty in adolescent and school health; and
- criteria to evaluate the competence of providers of adolescent and school health services, with universities and training institutions collaborating internationally to maximize the equality of existing programmes in the European Region.

Russell Viner of the **Institute of Child Health, London, United Kingdom (England)**, stated that while

the United Kingdom has very fine doctors and nurses, young people say that they are not good in terms of understanding young people's priorities and interests and in communicating with and engaging with them. While adolescence should be the healthiest time of life, it is not – mortality and morbidity both increase during adolescence. Understanding why injury and illness occur in adolescence must be at the heart of any training for professionals.

In the last five years, there have been major advances in understandings of the development of the brain in adolescence, the result of which is the key element of adolescent behaviour – abstract thinking. Abstract thinking drives the search for identity, and the search for identity drives so many other things in adolescence. The combination of brain development, puberty and social development result in a range of behaviours which may include risky activities. Practitioners need to understand that all of the things that emerge in clinical interactions as important to adolescents arise from the circumstances of adolescent development – if they do not do so, Dr Viner suggested, they will “miss the boat”.

This means that the health workforce needs to be trained in the professional skills necessary to work with young people. These are about the individual-level skills of:

- developmentally appropriate, non-judgemental engagement that does not focus immediately on the problem, but on the person;
- risk assessment and protective factors in the young person and environment, perhaps focusing on the HEADSSS (home and peers; education; activities: drugs; safety; sex; suicide) approach;
- motivational approaches – many professional interventions are about changing behaviour, and behaviour does not change through providing information; it changes through engagement, understanding and motivation, and motivational interviewing techniques and solution-focused approaches are relatively easy to teach to health professionals.

These approaches have been used to develop the “Adolescent health project”, an online resource funded by the Department of Health in England. Its 14 modules cover all of academic health, and many health professionals are now registered to use the materials.

Outcomes and discussions from this session are reflected in suggested action areas 17, 19 and 23.

The final session of the meeting, chaired by **Gunta Lazdane, WHO Regional Office for Europe**, focused on framing the recommendations from meeting participants and the EYF, described above. The discussions, comments, ideas and recommendations that emerged from this session have been reflected in the **Meeting suggested action areas**, which are presented in the next section. Mechanisms were also in place throughout the meeting to enable participants to record their ideas for suggested action areas, and these, if validated in plenary discussion, are also reflected in the statements.

Outcomes and discussions from this session are reflected in all suggested action areas.

References

1. *Convention on the Rights of the Child*. New York, United Nations, 1989 (<http://www.unicef.org/crc/>, accessed 4 September 2009).
2. *Tallinn Charter: Health Systems for Health and Wealth*. Copenhagen, WHO Regional Office for Europe, 2008 (http://www.euro.who.int/document/hsm/6_hsc08_edoc06.pdf, accessed 10 November 2009).
3. *A snapshot of the health of young people in Europe. A report prepared for the European Commission conference on youth health, Brussels, Belgium, 9–10 July 2009*. Copenhagen, WHO Regional Office for Europe, 2008 (<http://94.23.50.42/youth/documents/A%20snapshot%20of%20the%20health%20of%20young%20people%20in%20Europe.pdf>, accessed 10 November 2009).
4. Currie C et al., eds. *Inequalities in young people's health. Health behaviour in school-aged children: international report from the 2005/2006 survey*. Copenhagen, WHO Regional Office for Europe, 2008 (Health policy for children and adolescents No. 5; http://www.euro.who.int/datapublications/Publications/Catalogue/20080616_1, accessed 20 July 2009).
5. *The children's plan: building brighter futures*. London, Department for Children, Schools and Families, 2007 (<http://>

- publications.dcsf.gov.uk/eOrderingDownload/The_Childrens_Plan.pdf, accessed 10 November 2009).
6. *Healthy lives, brighter futures. The strategy for children and young people's health*. London, Department for Children, Schools and Families/Department of Health, 2009 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_094397.pdf, accessed 10 November 2009).
 7. *Equally well: report of the Ministerial Task Force on Health Inequalities*. Edinburgh, Scottish Government, 2008 (<http://www.scotland.gov.uk/Publications/2008/06/25104032/0>, accessed 10 November 2009).
 8. *A curriculum for excellence*. Edinburgh, Scottish Executive, 2004 (<http://www.scotland.gov.uk/Publications/2004/11/20178/45862>, accessed 10 November 2009).
 9. *Guide for developing policies on the sexual and reproductive health and rights of young people in Europe*. Brussels, International Planned Parenthood Federation European Network, 2007 (<http://www.ippfen.org/NR/rdonlyres/4A7E8620-5009-4170-918B-E2891FC4161B/0/policyguide.pdf>, accessed 10 November 2009).
 10. *WHO European strategy for child and adolescent health and development*. Copenhagen, WHO Regional Office for Europe, 2005 (http://www.euro.who.int/childhealthdev/strategy/20060919_1, accessed 20 July 2009).
 11. *You're welcome. Quality criteria for making health services young people friendly*. London, Department of Health, 2007 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_073829.pdf, accessed 25 November 2009).
 12. *Provide: strengthening youth friendly services*. London, International Planned Parenthood Federation, 2008 (<http://www.ippf.org/NR/rdonlyres/61BA967F-5D07-41EA-907D-C8AB128E002D/0/InspireProvide.pdf>, accessed 10 November 2009).
 13. Miller R, Rollnick S, Butler CC. *Motivational interviewing in health care: helping patients change behavior*. New York, NY, Guilford Press, 2007.
 14. Tait RJ, Hulse GK. A systematic review of the effectiveness of brief interventions with substance using adolescents by type of drug. *Drug Alcohol Rev*, 2003, 22:337–346.
 15. *Standards for peer-education programmes*. New York, NY, United Nations Population Fund and Youth Peer Education Network (Y-PEER), 2005 (http://www.fhi.org/NR/rdonlyres/ela4kfwnkxyflhfxw74a5rp6pvxpnfttjsw7wtg5tvu7l5xsp2w7uoo774qlp_sqtuvf6ck7nwedl/standardsbook1enyt.pdf, accessed 10 November 2009).
 16. *21st century schools: a world-class education for every child*. London, Department for Children, Schools and Families, 2008 (<http://publications.dcsf.gov.uk/eOrderingDownload/DCSF-01044-2008.pdf>, accessed 11 November 2009).
 17. *Better schools through health: the Vilnius Resolution*. Woerden, The Netherlands, Schools for Health in Europe, 2009 (<http://www.schoolsforhealth.eu/index.cfm?act=esite.tonen&pagina=37>, accessed 26 November 2009).

Meeting suggested action areas

Meeting on Youth-friendly Health Policies and Services, 21–23 September 2009

Participants of the Meeting on Youth-friendly Health Policies and Services held in Edinburgh, United Kingdom (Scotland) on 21–23 September 2009 respectfully request decision-makers in Member States of the WHO European Region to consider the following lessons learnt and take appropriate actions.

The suggested action areas are based on research evidence presented at the meeting, the experience of participants representing a wide range of government agencies and national and international organizations concerned with youth health, and young people's voices as gathered through a survey conducted in advance for the meeting. Participants came from 35 countries of the European Region and included representatives of the European Youth Forum and young people.

Meeting participants believe the suggested action areas will prove useful in informing decision-makers' deliberations on creating and developing youth-friendly health policies and services in their own countries and internationally.

Participants perceived that WHO technical support in articulating evidence-based policy options and stimulating the generation and dissemination of knowledge, including the measurement of performance and exchange of experiences, would provide a very welcome impetus in accelerating implementation of the suggested actions, which are presented below.

Supportive policies

1. Evidence-informed policies that promote and support the use of youth-friendly health services make strongly positive contributions to sustaining and improving the health and well-being status of adolescents¹ and young people² in the European Region. Policy-makers are therefore encouraged to increase their efforts in putting such policies in place.

Human rights-based approach to policy development

2. Legal, policy and regulatory frameworks are enabling for young people's health and development when aligned with ratified human rights conventions (such as the United Nations *Convention on the Rights of the Child* and the *Convention on the Elimination of All Forms of Discrimination against Women*). This is particularly the case when they reflect principles of non-discrimination, evolving capacities, participation and promotion of the best interests of adolescents and young people. Ongoing attention is necessary to ensure that existing laws, policies, norms and regulations do not contradict these principles. The development of guidelines on assessing adolescents' and young people's competence to make informed autonomous decisions about their own health, including sexual and reproductive health, will support efforts health practitioners and others to provide ethical youth-friendly services.

¹ "Adolescents" refers to those aged between 10 and 19 years.

² "Young people" refers to those aged between 10 and 24 years.

Addressing inequalities

3. Health behaviours and patterns of access to health services among adolescents and young people tend to follow clearly identified gender-specific determinants. Policies targeting adolescents and young people that reflect these gender-specific determinants, and which are informed by sex-disaggregated data, are likely to be more effective.

4. Social and health inequalities continue to disadvantage a wide range of adolescents and young people in the European Region. Policy developments that acknowledge, identify and address the specific needs of the most disadvantaged and most-at-risk adolescents (MARA) and young people³ represent a powerful tool in effectively addressing their health needs.

Young people's health in all policies

5. It is widely recognized that sectors other than health, including education, justice, transport, sport and leisure, the commercial sector and the media, have a significant impact on adolescents' and young people's health and health behaviours. Efforts made by ministries of health to advocate on behalf of young people's health to government ministries, parliamentarians and politicians could be supported by the development of a guidance advocacy package, especially on sensitive issues such as sexual and reproductive health.

6. There is evidence to suggest that sexuality education is most effective when based on curriculum-based programmes and comprehensive life skills-based approaches. Further efforts to ensure that such programmes are available and that their development, content and implementation follow internationally agreed standards based on best practices are likely to produce benefits.

Young people's empowerment and participation

7. "Empowerment" and "participation" do not mean the same thing. Meeting participants recognize that young people's participation in influencing the policies that affect their health and well-being cannot be secured unless they are *empowered*, and that their empowerment means little unless they have the opportunity to *participate*. This means that both aspects need to be embedded in policy and service development, implementation, monitoring and evaluation.

8. Participation of adolescents and young people in making decisions that affect their lives is the most effective way of translating decisions into positive action. Ensuring that explicit mechanisms and structures are in place to enable young people's empowerment and participation at country and international levels is most likely to lead to successful outcomes.

Parents' and community involvement

9. Parents are the primary carers for the vast majority of adolescents and young people in the European Region. They constitute a vital resource for promoting young people's health and well-being. Their support and the support of communities to increase the use of services by young people is crucial. Programmes are more likely to be effective if they reflect this fact and promote parents' abilities to support their children to adopt healthy behaviours and lifestyles.

³MARA include, but are not restricted to, adolescents who have immigrant backgrounds, refugees, those with disabilities or chronic ill health, those whose health is put at risk through, for example, alcohol, substance and/or tobacco misuse and unsafe sex practices, those with mental health disorders and/or learning disabilities, those who are parentless, homeless or who are looked after in institutions, those who are excluded from (or who place themselves outside) mainstream education and employment settings and those who suffer discrimination on racial, religious, gender, sexuality, economic or any other grounds.

Evidence-based policy development

10. The development of evidence-based policies on adolescents' and young people's health is supported and enabled through national health information systems that are capable of supplying age- and sex-disaggregated data. Reliable and relevant information systems emerge as a result of having appropriate policy in place.

11. The Health Behaviour in School-aged Children (HBSC) study has proven a valuable source of evidence on health-related behaviours of pupils. There is evidence that HBSC data-informed policy development is growing in participating countries. Meeting participants therefore encourage countries in the WHO European Region who are not already part of the study to join the HBSC network. This will enable them to collect reliable, comparative data on the health behaviours of children and adolescents in their countries.

12. Reliable and comparable data on health-related behaviours of children under 11 years and over 15 years, and those who are outside the mainstream school environment, are scarce, if not non-existent. There is a need to develop research methodologies to enable health-related data to be collected from children and adolescents not covered by the HBSC study.

13. Greater understanding of the risk profiles and needs of adolescents and young people engaging in behaviours or living in circumstances that put their health and well-being at highest risk⁴ can be gained through the collection of national- and community-level strategic information. Such information is most useful when it focuses on the main barriers to the demand and provision of health and social services to these vulnerable populations.

14. There is wide recognition that implementation of laws, policies and strategies in the area of young people's health needs to be monitored to assess progress. This process can be facilitated by the establishment of country-level groups, committees or working parties specifically tasked with monitoring of policy implementation. These should emerge from a wide range of stakeholders, including adolescents and young people and youth-led organizations.

15. Experience-sharing within and between countries on policies, systems and services designed to support young people's health and well-being serves to inform, educate and inspire all involved and enable best practice to be identified and disseminated.

Financing and health care workforce capacity

16. Investment in the health and well-being of young people *now* is an investment in the health and well-being of the adult population of the future. It is consequently an investment in the future prosperity of countries. This presents implications for policy-makers in ensuring that young people get an equitable share of targeted health resources.

Health care workforce

17. Appropriately educated health care personnel are crucial to the provision of comprehensive, integrated youth-friendly health care. Education strategies that target both the existing and emerging workforce and which aim to ensure relevant skill mixes, including working in multidisciplinary, multi-agency teams providing coordinated care, may effectively contribute to this development. Primary care providers may play an important role, if appropriately trained in youth-friendly approaches.

⁴This includes, but is not restricted to, those engaging in illicit drug use, sex workers, those living or working on the streets, juvenile offenders and socially excluded and marginalized youth such as those from ethnic minorities and school drop-outs.

18. There is evidence to suggest that there are advantages in engaging a young workforce to provide services to MARA. A younger workforce may be more able to identify with, and empathize with, the specific challenges MARA face and enable more effective communication and trusting relationships to emerge. Meeting the changing health and social care needs of MARA requires specific training and capacity-strengthening measures to support professionals in providing appropriate, timely and effective services.

19. The success of youth-friendly health services is not only dependent on competent, appropriately trained health care professionals. It also needs contributions from many individuals and teams who work in other sectors and in nongovernmental organizations and community bodies, including youth-led organizations. Meeting their training and capacity-building needs requires the availability of sustainable funding.

20. The value of non-formal learning, non-formal education and peer education approaches in promoting the health and well-being of adolescents and young people is now well-recognized. They need to be further encouraged and supported.

21. Evidence presented to the meeting by the European Youth Forum indicates that young people identify teachers and doctors as particularly important groups in developing knowledge and understanding of adolescents' and young people's health needs. This reflects the need to ensure that teachers and health care professionals are able to adequately respond to this challenge.

Resources for school health

22. Evidence from a survey of school health services in the European Region indicate a general lack of funding, insufficient orientation towards health promotion, a mismatch between priority health problems and services provided, and school health personnel having insufficient training to provide appropriate services. Accelerated actions to address these issues and align school health service provision with pupils' needs are likely to increase the effectiveness of the service.

23. School health services will benefit from the development of a confident and competent school health service workforce throughout the European Region. The achievement of this aspiration may be supported through:

- the definition of minimal competences for professionals in adolescent/school health, including the development of recommendations regarding the training and competencies of school nurses;
- the development of a European standard for professional training in adolescent/school health, including evaluation tools and quality indicators and the recognition of a (sub)specialty of adolescent health care/school health care;
- the creation of criteria to evaluate the competence of providers in adolescent/school health care; and
- the promotion of international collaboration involving universities and training institutions to maximize the educational quality of existing preparation programmes in the European Region.

Financial accessibility and incentives

24. With the current financial crisis and diminished employment opportunities, young people's financial vulnerability is increasing. Relatively small personal expenditure to access health care services would be catastrophic for certain groups of young people. While acknowledging that it might not be feasible for systemic reasons to provide services free-of-charge for everyone, it is also important to recognize that the provision of youth-friendly health services that are free-of-charge at point of use would lead to greater equity of provision and wider uptake of health-related information and treatment, particularly by MARA.

25. There is evidence that payment mechanisms can discriminate against the provision of, and access to, key services such as counselling and outreach activities, rather than stimulating their development and uptake.

Providers' payment mechanisms are therefore a key element in actions designed to encourage the provision of services that many adolescents and young people consider essential.

Youth-friendly health service delivery

Developing youth-friendly health services

26. Resources would be best-used through making existing services youth friendly and making primary care services responsive to adolescents' and young people's needs as a key strategy. Other enhancement strategies, such as developing paediatric services' competencies in dealing with adolescents, might complement these efforts. There is good evidence to support the need for policy and professional practice to tackle the challenges faced by young people in the transition period from paediatric to adult care.

27. There is a variety of youth-friendly health service models in the European Region, the most effective of which are based on:

- provision of comprehensive services, with emphasis on prevention as well as treatment, based on assessment of all health needs and preferences of adolescents and young people;
- recognition of their rights (including the right to confidentiality);
- recognition of the different needs and health-seeking behaviours of boys and girls; and
- the provision of counselling and psychological support services.

28. The most effective services for MARA are those that:

- provide services in a way that fully respects their best interests and rights;
- ensure the involvement of all relevant layers of the health system (including primary health care facilities, family doctors and community-based youth-oriented and specialist services) in service design and delivery;
- provide not only structured treatment⁵ for those who are already engaging in high-risk practices, but also early interventions focusing on prevention of high-risk behaviours among those who are highly vulnerable; and
- ensure close links, good coordination and bilateral referral systems between government-provided services and services from civil society organizations that are in contact with MARA through outreach mechanisms

29. Services for adolescents and young people are more effective when school health services, health promoting schools initiatives and youth-friendly health services are interlinked.

30. Evidence presented to the meeting by the European Youth Forum indicates that young people prefer youth-friendly services that do not have links with, or include the involvement of, commercial or industry interests.

Quality assurance

31. Youth-friendly health services form part of overall efforts to improve the client-responsiveness of health systems. Measuring quality and coverage of health systems on a regular basis, with young people participating at all stages, offers strong support to achieving this aspiration. The identification of measurable standards, criteria and indicators derived from the scope of the service and the specific contribution it can make to adolescents' and young people's health and development is also supportive.

32. Addressing the specific needs of MARA can be ensured through key quality-assuring elements of the youth-friendly health service (such as availability, accessibility, acceptability, appropriateness (including confidentiality) and equity) through the specific "lens" of the needs of MARA.

⁵"Structured treatment" involves assessment and care interventions that combine a range of health, social and child protection services, including the establishment of functional referral systems.

Marketing

33. Marketing strategies are important tools in raising awareness among young people and the wider community about the scope and nature of youth-friendly health services. These strategies need to be gender sensitive to reach the different needs and behaviours of boys and girls.

34. Evidence presented to the meeting by the European Youth Forum supports the use of the following techniques in marketing campaigns for youth-friendly health services:

- targeting of schools, youth centres and gyms, but also including street-level awareness-raising through the use of billboard and other forms of youth-friendly advertising and dissemination of information through shopping malls;
- using communication media that are popular with young people, such as the Internet, social networking web sites and mobile phone texting, but remaining aware of the needs of young people who do not possess mobile phones and have no access to the Internet;
- ensuring that campaigns create opportunities for involvement of, and dialogue with, young people and are not simply vehicles for disseminating information from services to them; and
- engaging the support of celebrities who are well-known to adolescents and young people to promote health and well-being messages, which may help to make health a more “attractive” subject for young people.

35. The media and modern technologies have an important role to play in communicating health in an attractive way and in engaging with adolescents and young people about health and health care-seeking behaviours. Benefits will accrue from decision-makers and health care practitioners paying increasing attention to use of these technologies and making them part of service delivery models.

Partnerships

36. There are already many partners working in collaboration throughout the European Region to ensure the smooth delivery of youth-friendly health services and networking. Further actions to enhance partnership working will bring further benefits to adolescents and young people.

Leadership

37. To maximize the effects of the above-mentioned actions in improving young people’s health, it is important for the health sector to engage with other sectors to:

- ensure that health is recognized as one of the socially valued outcomes of all policies; and
- build understanding that investing in health is the right thing to do, not only from a human rights perspective, but also because it is money well spent.

This requires inclusive leadership from health authorities and ministries of health, engaging with a variety of sectors and stakeholders beyond the boundaries of the health sector, to set the vision for health system development, fulfil the mandate and responsibility for developing legislation and regulating and enforcing health policies, and gather intelligence on health and its social, economic and environmental determinants.

Country case studies

Georgia: youth-friendly health services and policies

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Executive summary

The initial period of independence for Georgia resulted in difficult transition years that were exacerbated by civil war, displacement of people from two conflict zones, lack of financial resources and an economic crisis.

The health status of the population, particularly in relation to reproductive health, gave cause for concern due to increases in the numbers of maternal deaths, unsafe abortions and pregnancies among adolescents. Limited access to reproductive health services and information, particularly for young people, was partly responsible for creating this situation.

The country's health services, which had been inherited from the Soviet health system, were generally of poor quality and were mainly focused on the needs of women. Lack of male involvement with reproductive health services gave rise to concern, while concepts such as youth-oriented services and issues of confidentiality and the right of choice had to be introduced throughout the country.

The Georgian Government embarked on an ambitious and complex reform processes that has been accelerated during the last five years. The United Nations Populations Fund (UNFPA) supports the Georgian Government in its efforts to achieve the International Conference on Population and Development (ICPD) programme of action and the Millennium Development Goals (MDGs), with a special focus on MDG 5: improving maternal health and achieving universal access to reproductive health services.

One of the important aspects of the UNFPA programme is sexual and reproductive health services for young people. By promoting the reproductive rights of young people and increasing their access to high-quality, gender-sensitive sexual and reproductive health information and youth-friendly services, the organization has made an important investment in improving sexual and reproductive health among the country's young people.

UNFPA has established youth-friendly medical information centres in all regions of the country under a joint European Union (EU)/UNFPA project called "Reproductive health initiative for youth in the South Caucasus" (RHIYC). Facing the challenges posed by current health reforms and privatization of health care facilities in Georgia, UNFPA utilized a new partnership strategy in establishing youth-friendly services. The strategy aimed to find the most-reliable partners at primary health care level from both the public and private sectors who were committed to collaborate in the development of sustainable and cost-effective youth-friendly services.

The case study focuses on the sexual and reproductive health needs of young people and describes obstacles in accessing sexual and reproductive health information and services, the changing health care environment, the importance of partnership strategies, the operation of a youth-friendly services model and issues around sustainability.

Background

The initial period of independence for Georgia resulted in difficult transition years that were exacerbated by civil war, displacement of people from two conflict zones, lack of financial resources and an economic crisis.

The health status of the population, particularly reproductive health, gave cause for concern due to increases in the numbers of maternal deaths, unsafe abortions and pregnancies among adolescents. This was partly due to limited access to reproductive health services and information, particularly for young people. Health services in general, which had been inherited from the Soviet health system, were of poor quality and were

mainly focused on the needs of women. Lack of male involvement with reproductive health services gave rise to concern, and youth-oriented services and issues of confidentiality and the right of choice were new concepts that had to be introduced throughout the country.

Although the education level of men and women in Georgia was high, general knowledge of family planning, understanding of sexual and reproductive health issues and awareness of reproductive rights were limited due to cultural stigmas and to a lack of supportive policies and education on healthy lifestyles. Misconceptions and the population's negative attitude towards modern methods of family planning were the main causes of high rates of abortions; in fact, abortion was considered the only method of birth control.

The two most serious sexual and reproductive health problems facing young people in Georgia then were sexually transmitted infections (STIs) and pregnancy; they remain so today. Sexual activity generally begins at an earlier age than in the past, but young people have inadequate access to information about safe sex and contraception.

HIV/AIDS is another grave concern in the country. HIV/AIDS prevalence rates remain at low levels currently, but the high-risk environment, including widespread injecting drug use and intensive population movements across neighbouring high-prevalence countries, cause Georgia to be at risk of a wide-scale epidemic.

Despite ongoing reforms in the health care sector, a state funding focus on maternal and child health, the development of insurance mechanisms and improvements in specific health indicators, there is still a number of problem areas associated with a reduction in public financing of health care that affect reproductive health services. Resolution of these problems is essential, particularly when the current demographic situation and ageing population problem in Georgia is taken into account. The problem is further complicated by socioeconomic conditions that prevent women from being able to access and afford an adequate level of health care.

In Georgia, young people constitute 25% of the total population. The latest study (1) showed that more than half of women (58.9%) cannot afford medical care because of economic constraints. The survey demonstrated that the highest birth rate was found among females between the ages of 20 and 24 years. More than half of live births were reported among females in the 15–24 years age range. The mean age for marriage (21.6 years) and the average age of commencing sexual activity (21.3 years) among females were almost the same, while the mean age for marriage among males (25.1 years) is significantly higher than the mean age for first sexual intercourse (17.5 years).

These findings demonstrate that there is still a high risk of unintended pregnancy and STIs that is largely attributable to sexual intercourse among unmarried youth without proper use of contraceptive precautions, or without the use of precautions at all.

Surveys conducted in 1999 (2) and 2005 (1) showed that the abortion rate among adolescent females had significantly reduced (by half) by 2005 as a result of intensive efforts targeted at behaviour change and peer education. The surveys also show that the contraceptive prevalence rate has increased in recent years (40.5% in 1999 and 47.3% in 2005), reflecting rises in availability of modern birth control methods. To make sustainable improvements in youth reproductive behaviour, however, it is critical to strengthen the quality of, access to and affordability of reproductive health services.

The main challenge here is the lack of youth-friendly reproductive health services. According to a report published in 2002 (3), most young people felt they needed more information about services available to them and an adequate level of knowledge about different family planning methods. Young females and teenagers believed the best source of information about reproductive and sexual health services was the medical profession, but only 1.7% of 15–19-year-old and 5.4% of 20–24-year-old females had received such information from health care workers. The most common source of information was close friends and peers

who may have had some experience with the system. Young people were generally distrustful about the providers of medical services and visited them only in emergencies.

Studies of reproductive and sexual health services carried out in Georgia (1–4) have revealed:

- a low level of knowledge among young people (despite their good awareness of various reproductive and sexual health issues);
- poor utilization of reproductive and sexual health services; and
- an inadequate level of medical treatment and consultations in reproductive and sexual health services.

Difficulties encountered in accessing and affording reproductive and sexual health services among young people remain an obstacle to health improvement. Improvement in the reproductive health status of young people is a priority in Georgia, not only for medical reasons, but also from social and developmental perspectives. UNFPA is working in partnership with governmental and nongovernmental organizations (NGOs), national institutions and private sector organizations to improve youth access to services.

To achieve this, comprehensive state policies, regulations and a legislative framework need to be in place. Health care legislation in Georgia creates the basis for protection of human rights, which corresponds to international standards, treaties and conventions ratified by Georgia. At present, several legislative acts in the field of health care address reproductive rights:

- Law on Health Care
- Law on the Rights of Patients
- Law on Medical Activity
- Law on Public Health
- Law on Acquired Immune Deficiency Syndrome/AIDS.⁶

One of the most important aspects is the policy environment and legislative framework in which youth-friendly services operate. The Law on the Rights of Patients aims to protect citizens' rights to health care and to ensure the inviolability of their dignity and privacy. It regulates rights to information (Article 16), informed consent (Article 22), age of informed consent, confidentiality, privacy (Article 27), parental consent (which affects young people's access to services) and special provisions on the rights of minors (articles 40–43).

The *Georgia national reproductive health policy* document (5) and the strategic plan for reproductive health in Georgia are also significant. These serve as a foundation for detailed annual planning for provision of reproductive health information and services. A comprehensive policy on young people is under development.

Health system context and health services available to young people

Demand on reproductive and sexual health services from the population, particularly young people, is influenced by a number of medical and non-medical factors. Quality, accessibility and affordability and culture-, gender- and age-sensitive approaches are the issues traditionally considered in all strategies. In the process of health care reform and privatization of health facilities in Georgia, however, developing the role of, and creating partnerships with, the private sector has become an absolutely critical priority for ensuring the sustainability of services.

In the early 2000s, the primary health care system in Georgia consisted of various outpatient facilities at local level (adult, child and women's polyclinics and specialized dispensaries), along with village-level ambulatory clinics staffed by one paediatrician or general practitioner and one nurse per 2000 population. There were virtually no reproductive health services offered at these village facilities – physicians were

⁶The newly prepared draft law on AIDS is currently under discussion.

traditionally neither trained nor authorized to provide basic reproductive health care at village level, and the ambulatory clinics were neither equipped nor resourced to enable them to do so.

Women receive essential reproductive health services – mainly pregnancy and delivery care, family planning services and abortion, clinical diagnosis and treatment of STIs and reproductive tract infections – through the women’s outpatient clinics (“women’s consultations”) and maternity hospitals located at local and regional centres. The distance of these facilities from many villages, particularly in the mountainous regions, constitutes both a geographic and financial barrier to access for many women.

The only reproductive health services offered to (and utilized by) men are diagnosis and treatment of STIs through dermatovenereological clinics. Men may also consult urologists through adult olynics.

Table 1 presents the facilities that offered some sort of reproductive health services at village and regional level in 2005. It includes lists of those reproductive health-related services that, according to the state health programmes and regulations governing the licensing of medical activities, should have been made available.

Table 1. Reproductive health services in the primary health care system, 2005

| Rural ambulatory | Polyclinic | Women's consultation | Reproductive health "cabinets" | Dermato-venereological dispensary |
|--|---|---|---|---|
| Diagnosis of pregnancy and referral for antenatal care Monitoring of pregnancies and counselling on self-care Postpartum care for women and monitoring of infant growth and health | Detection of pregnancy and referral Paediatric care for sick infants Well-baby care | Diagnosis of pregnancy Pregnancy testing Antenatal care Postpartum care for women STI/reproductive tract infection diagnosis and treatment (in women) Ultrasound Clinical breast examination Family planning counselling Abortion | Family planning counselling and contraceptive method provision Counselling, treatment and/or referral for infertility Diagnosis and treatment of STIs/ reproductive tract infections Diagnosis and treatment of other gynaecological and endocrine disorders | STI diagnosis and treatment (mostly in men) |

Sexual and reproductive health services, including family planning services, are provided largely in special “reproductive health cabinets” (sexual and reproductive health service units) by gynaecologists who have trained and qualified as reproductologists. There are approximately 75 reproductive health cabinets in the country, the majority of which are located within women’s consultation centres or maternity hospitals. These reproductive health cabinets and the services offered by the reproductologists staffing them have been largely supported by donor funds and out-of-pocket payments.

The integration of sexual and reproductive health services at primary health care level is the objective of the health care reform that is currently being implemented despite serious obstacles such as military conflicts, displacement of populations and related budgetary constraints. The sexual and reproductive health programmes are coordinated by the Reproductive Health National Council, chaired by the First Lady of Georgia.

UNFPA has been an important source of support to Georgia since 1996. It has aimed to improve the quality of, and access to, sexual and reproductive health services and to increase the demand of the population, particularly young people, for services. Youth sexual and reproductive health is the strategic priority and is integrated in all programme aspects and components in Georgia.

UNFPA has been providing technical and financial support to Georgia, supplying equipment, developing services protocols and guidelines, training service providers, conducting surveys and analytical studies and educating the public on sexual and reproductive health and reproductive rights. The UNFPA programme has also attempted to bridge the gap in geographic accessibility through deployment of mobile teams of reproductive health service providers. More recently, the United States Agency for International Development (USAID)-supported “Healthy women in Georgia” initiative has provided training and a supply of contraceptives to providers in over 200 village ambulatories, newly renovated primary health care centres and outpatient facilities in Tbilisi and selected regions of the country.

The government does not have a separate youth-oriented sexual and reproductive health programme, but state support is channelled through the following state health programmes:

- antenatal care (the recommended four visits are funded by the state; additional visits, tests or recommended treatments must be covered by the client);
- delivery care (fully, at 400 lari, for families registered with the social assistance system as living below the poverty line, and partially, at 200 lari, for others who request state assistance; these services are provided at select maternity hospitals, contracted for this purpose by the state through the State United Social Insurance Fund);
- counselling, testing and treatment for HIV (through resources provided to the Georgian Government by the Global Fund for Combating HIV/AIDs, Tuberculosis and Malaria); and
- contraceptives (provided free of charge through the reproductive health cabinets supplied by UNFPA; payment for counselling is made by the clients).

Recent initiatives on youth-friendly health services

UNFPA supports the Georgian Government in implementing the programme of action from the International Conference on Population and Development (ICPD) held in Cairo, Egypt in September 1994 and the Millennium Development Goals (MDGs) (6), which lay the foundations for improved reproductive health, poverty reduction and economic empowerment of the population.

UNFPA fully established its country office in Georgia in 1999. The UNFPA Georgia Country Programme, run in partnership with the Georgian Government, revolves around three core areas:

- reproductive health
- population and development
- gender.

It takes this programme forward through addressing topical issues such as the quality and accessibility of reproductive health services, gender equality and the availability of quality data for development.

One of the important aspects of the programme is young people’s sexual and reproductive health. The organization provides important investment aimed at preventing sexual and reproductive health problems from an early age by promoting young people’s access to quality sexual and reproductive health information

and gender-sensitive, youth-friendly services.

Youth-friendly, gender-sensitive services proffer solutions to many problems, including dismissing taboos round sexual health and involving men in reproductive health issues by increasing their access to information and services. The strategy on youth-friendly services agreed by UNFPA and the Georgian Government covers topics related to capacity-building of reproductive health service providers, improving the structures and conditions of health facilities, and encouraging youth participation in programme design, implementation and monitoring.

The development of youth-friendly sexual and reproductive health services has had a critical impact on the achievement of recognized reproductive rights for young people and the improvement of youth sexual and reproductive health indicators in Georgia.

As a post-Soviet country, Georgia faced the following challenges:

- issues around the affordability of quality reproductive health services
- limited access to reproductive health services for males
- lack of availability of youth-friendly reproductive health services.

To meet these challenges, youth-friendly medical information centres have begun to be established in all regions of Georgia under the “Contributing to the expansion of youth-friendly sexual and reproductive health services, information and counselling” stream of the RHIYC programme.

It was decided to establish two types of reproductive health services for young people:

- youth-friendly reproductive health information centres at universities in Georgia to improve access to quality information; and
- youth-friendly reproductive health information medical centres, to be established in the capital and all 10 regions of Georgia.

The strategic plan developed by UNFPA and its partners consists of several interlinked important steps.

Step 1. Ask young people to determine their needs

The first step in specifying priorities and actions to establish youth-friendly sexual and reproductive health services was to review relevant surveys and analytical studies to determine young people’s needs and identify obstacles to accessing information and services. In addition, a special survey on youth-friendly reproductive health services in Georgia was conducted in 2007 to assess the “youth friendliness” of existing sexual and reproductive health services and to develop recommendations on how to fill existing gaps with new service units, meeting the needs of young people and international (WHO) standards for youth-friendly services.

During the survey, in-depth interviews based on a specially designed questionnaire which focused on issues such as physical and financial accessibility of sexual and reproductive health services and confidentiality and privacy issues were conducted. In addition, five different scenarios were developed to determine the quality and adequacy of medical care and consultations. Specially trained interviewers visited sexual and reproductive health services with these scenarios, which focused on the assessment of quality of medical consultations and services, the attitudes of medical personnel towards patients, and confidentiality and environmental issues.

The survey findings and recommendations provided the basis for development of the strategic plan, with a detailed description of youth-friendly services and the implementation of an appropriately targeted strategy for the development of youth-friendly sexual and reproductive health services, leading to the overall

improvement of youth sexual and reproductive health. Twenty-one youth-friendly sexual and reproductive health services (information and medical information centres) are now in the process of opening and will be fully operational by September 2009 all over Georgia.

Step 2. Changing environment, adequate partnership strategies

The process of privatization of health care facilities in Georgia changed the health care environment and caused an alteration in initial plans to create youth-friendly services.

To help meet these challenges, UNFPA deployed a new partnership strategy which aimed to identify the most-reliable partners at primary health care level (both public and private sector) who were committed to collaborate in the development of sustainable, cost-effective youth-friendly services. UNFPA invited applications and carefully assessed submissions, taking into account a wide range of issues such as geographic coverage, capacity, service gaps and development opportunities. Interested potential partners had to submit specific information on:

- the physical dimensions of their facility, with an indication of the space (15–20m²) to be allocated for a reproductive health medical centre;
- their human resources, with details of appropriately qualified staff (family physician and/or obstetrician/gynaecologist);
- the status of their license to conduct medical activity;
- the reproductive health-related medical services they could provide;
- their capacity for providing laboratory tests; and
- their Internet capability.

Additionally, the selection process considered the ability and commitment of potential partners to ensure:

- youth-friendly services were affordable to young people
- access for young males to quality reproductive health services
- geographical accessibility to reproductive health services for young people.

Sixteen primary health care facilities were subsequently selected to provide the youth-friendly sexual and reproductive health services and to network with five information centres, also developed by the project. The new partners hosting the centres confirmed their readiness to fulfil their obligations to deliver youth-friendly services over the next five years by signing partnership agreements.

Step 3. Youth-friendly services: operation and future

Operation of the services is focused on high-quality service delivery ensured through UNFPA support across several areas:

- training of medical staff and peer educators;
- development of service guidelines and protocols;
- supply of medical equipment;
- supply of rehabilitation health commodities, including family planning;
- supply of information, education and communication materials developed for youth;
- supply of communication tools and equipment (computer, telephone, Internet); and
- the RHIYC special web site “For youth” (<http://www.foryouth.ge/net>), providing information and knowledge-sharing tools.

At present, the youth-friendly services provide the services shown in Table 2 free of charge.

Table 2. Services provided by youth-friendly services

| Youth-friendly reproductive health information centres at universities | Youth-friendly reproductive health information-medical centres |
|--|--|
| <ul style="list-style-type: none"> ● Peer education ● Counselling ● Provision of information, education and communication materials on, for example, puberty, sexuality, family planning, pregnancy and motherhood, gender, healthy lifestyle, HIV/AIDS and unsafe behaviours ● Provision of information on local sexual and reproductive health services (location, cost and "youth friendliness") ● Access to Internet ● Condom supply | <ul style="list-style-type: none"> ● Peer education ● Counselling ● Provision of information, education and communication materials on, for example, puberty, sexuality, family planning, pregnancy and motherhood, gender, healthy lifestyle, HIV/AIDS and unsafe behaviours ● Provision of information on local sexual and reproductive health services (location, cost and "youth friendliness") ● Access to Internet ● Testing (STIs, HIV/AIDS, pregnancy) ● Gynaecological examination ● Provision of family planning methods ● Referral |

The sustainability of services is ensured by host facilities through the partnership agreements. Under these agreements, organizations are obliged to provide young people of both genders with free information and services for a minimum of five years; this will ensure the affordability of youth-friendly services for young people. UNFPA will provide centres with free contraceptives, test kits, information materials and training opportunities in accordance with the funding available.

The youth centres are, and will be, accountable to UNFPA and the Reproductive Health National Council through a specially designed accountability system. UNFPA will also continue its advocacy efforts to ensure a gradual takeover and sustainability of youth-friendly sexual and reproductive health services by integrating them with insurance mechanisms; the government and private sector organizations have already commenced work on this. At the same time, UNFPA continues to advocate for the development of youth policy which, in addition to other social development issues, will be focused on youth sexual and reproductive health.

Sustainability issues (financing, politics, other issues)

A diverse approach is needed to ensure the sustainability of youth-friendly reproductive health medical information centres. UNFPA works with all stakeholders (representatives of the legislative and executive branch, NGOs, independent experts, think tanks, medical professionals and young people) actively involved in implementation and improvement of the existing situation, policy strategies, country vision and legislative framework.

The services' sustainability is supported by the Georgian reproductive health policy framework established in accordance with Georgia's commitments under the ICPD programme of action (5). The aim of the framework is to "make accessible, through the primary health care system, reproductive health to all individuals of appropriate ages as soon as possible". The policy framework presents integrated packages of reproductive health services for each level of the health care system – primary, secondary and tertiary.

The model of youth-friendly services is therefore supportive of, and supported by, the primary health care reform process currently being undertaken in Georgia, and the initial package of reproductive health services will be offered within primary health care centres.

Based on the Georgian reproductive health policy framework, the government vision for organizing and providing reproductive health services at primary, secondary and tertiary levels is set out in Table 3.

Table 3. Georgian Government vision for organizing and providing reproductive health services

| Level of the health system | Reproductive health services available | Mode of payment/coverage |
|--|---|---|
| <p>Primary Primary health care centres and outpatient clinics</p> | <p>Family planning counselling and provision of selected methods Ante- and postnatal care Newborn and well-baby care STI counselling and referral to youth-friendly services Counselling, information and referral for men Counselling and referral for victims of family violence Health promotion and community education Specialized outpatient consultations and services (family planning, abortion, fertility, gynaecology, urology, oncology, paediatrics, etc.)</p> | <p>The majority of services offered through the primary care system will be covered under the Essential Packages (both state-provided and purchased through insurance) Possibility of introducing co-payments for some services for those who can afford them as incomes, utilization, and the cost of services increase over the period of policy implementation</p> |
| <p>Secondary General and multiprofile hospitals; specialized outpatient centres and emergency centres</p> | <p>Specialized outpatient consultations/ services (family planning, abortion, fertility, gynaecology, urology, oncology, paediatrics, etc.) Comprehensive obstetric and perinatal services Counselling, testing, treatment for STIs, including HIV; prevention of maternal-to-child transmission of HIV Basic surgery and specialized inpatient care (obstetrics, oncology, urology, fertility)</p> | <p>Family planning; antenatal and postnatal care; specialized consultations (referred from primary health care) – Essential Packages Consultation and diagnosis, including STI testing, (referred from primary health care) – Essential Packages Emergency services, including obstetrics – Essential Packages General obstetric care/normal delivery – Essential Packages, plus out-of-pocket payments/ insurance for additional services like private room, enhanced "hotel" services, etc. HIV treatment: prevention of maternal-to-child transmission of HIV and antiretroviral drugs for mother – Essential Packages Treatment of diagnosed conditions not covered under Essential Packages – supplementary insurance or out-of-pocket payments Surgery and specialized inpatient care – Essential Packages and out-of-pocket payments/insurance Non-referred specialized consultations and treatment out-of-pocket payment/ supplementary insurance</p> |
| <p>Tertiary Specialized centres and hospitals</p> | <p>Specialized outpatient consultations/ services (fertility, gynaecology, urology, oncology, paediatrics, etc.) Specialized and emergency obstetric and neonatal services; intensive care Surgery and specialized inpatient care (obstetrics, oncology, urology, fertility)</p> | <p>As above, all referred consultations covered under Essential Packages Emergency care – Essential Packages Specialized non-emergency therapy, surgery, medicines – supplementary insurance and/or out-of-pocket payments</p> |

Lessons learnt

The following are key lessons learnt from the process followed in Georgia.

- The goals of meeting the challenges of privatization of the health care sector and finding reliable partners to ensure youth-friendly reproductive health services partnerships with the private sector were achievable because of a careful selection process and assessment of organizational capacities, gaps and development opportunities.
- Trained and skilled human resources are among the most important factors for successful provision of youth-friendly services. Capacity-building for the provision of youth-friendly reproductive health services must be institutionalized at national level.
- Geographical accessibility to reproductive health services is an important part of the development of any strategies targeting youth and promoting equity in access.
- Advocacy for youth sexual and reproductive health and reproductive rights at legislative and executive government levels is important.

Conclusions and recommendations

Involvement of young people as a main reference group for the establishment of youth-friendly services has been important, but it is recommended that young people, particularly those who are at risk, are involved more in the decision-making process.

Survey findings and evidence-based data provided the basis for the development of an appropriately targeted strategy for youth-friendly sexual and reproductive health services which is leading to the overall improvement of youth sexual and reproductive health. However, more comprehensive data are needed to meet the challenges of the reform process and to further expand access to primary health care-based youth-friendly sexual and reproductive health services.

The project acknowledges the importance of capacity-building of health care providers in delivering youth-friendly health services, but there is a need to develop and ratify changes in undergraduate and postgraduate education curricula and the focus of short seminars for health care providers. In the Georgian context, capacity-building of health care providers should be oriented to adolescents' and young people's health-related issues, in close collaboration with academic institutions.

The criteria for youth-friendly services should be based on international standards, but must also be focused on country-specific, evidence-based standards, guidelines and protocols. The process described here used quality standards defined by WHO, but no nationally agreed standards have yet been developed and officially endorsed. UNFPA will accelerate this process, based on experience gained during programme development.

Private sector involvement is essential for the sustainability of youth-oriented services in countries in which health care reform is based on a privatization process. It is also important to ensure government support for the provision of certain basic packages of health services for young people that are accessible geographically and financially, and to define the basic and comprehensive packages of health services to be delivered at various level of care within the health care delivery system.

It is recommended that policy dialogue to define the roles and responsibilities of governmental and nongovernmental organizations in the provision of youth-friendly reproductive health services be strengthened.

One of the most important aspects of youth-friendly services is coverage. At present, coverage tends to benefit the mainstream youth population (because the youth-friendly services were established in universities and centres in the capital). It is recommended that a comprehensive vision on expanding the availability of

youth-friendly services to vulnerable groups and young people in rural settings be developed.

To remove barriers to youth-friendly reproductive health services and to improve demand, a proper regulatory framework should be put in place. At present, several legislative acts in the field of health care address young people's reproductive rights. The rights to information, informed consent, the age of informed consent, confidentiality, privacy and parental consent are regulated by the Law on the Rights of Patients. The Georgian *National reproductive health policy* document (5) and the strategic plan for reproductive health in Georgia serve as a foundation for detailed annual planning for provision of reproductive health information and services; however, a more comprehensive policy on youth is needed, and this is currently under development.

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References

1. *Reproductive health survey, Georgia*. Tbilisi, National Centre for Disease Control and Medical Statistics/Ministry of Labour, Health and Social Affairs/United Nations Populations Fund/United States Agency for International Development, 2005.
2. *Reproductive health survey, Georgia*. Tbilisi, National Centre for Disease Control and Medical Statistics/Ministry of Labour, Health and Social Affairs/United Nations Populations Fund/United States Agency for International Development, 1999.
3. *Adolescents' reproductive health survey, Georgia*. Tbilisi, United Nations Populations Fund, 2002.
4. *Male reproductive health survey in Georgia*. Tbilisi, United Nations Populations Fund, 2005.
5. *Georgia national reproductive health policy*. Tbilisi, Ministry of Labour, Health and Social Affairs, 2007.
6. *Millennium Development Goals and reproductive health priorities in Georgia*. Tbilisi, United Nations Populations Fund, 2003.

Portugal: youth-friendly health services and policies

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Executive summary

The plano nacional de saúde juvenil (PNSJ) [national youth health plan] included in the national health plan of 2006 specified youth health, including treatment and interventions with adolescents, as a priority. The youth health plan focuses on physical and human resources, logistics, services and health staff training.

Education is compulsory until the 9th grade in Portugal (this will be extended to the 12th grade in 2009/2010). Many measures are in place to improve school dropout (including the programme “New opportunities” and economic incentives to families) and retention (special educational programmes, remedial teaching, special needs education and special support) rates.

In 2005, the Ministry of Education decided to change health education in Portuguese schools to a regular, long-term, sustainable process. It created a working group, the Grupo de Trabalho para a Educação Sexual/ Educação para a Saúde (GTES) [Working Group on Sexual Education/Health Education] to present proposals to ensure by 2007 countrywide coverage of a schools curriculum that included health. GTES’ proposal, which subsequently became public policy and law, defined health education as compulsory across all school subjects and called for students’ and parents’ active participation.

The approval of Law 60/2009 in August 2009 enabled and reinforced public policies on health promotion in schools, particularly in relation to sexual education (now compulsory nationally from 1st to 12th grade). This law sets out that in 2010, all schools will have a “health space” where students can voluntarily access confidential health care and counselling. These “spaces” will operate within schools’ jurisdiction and will be supported by a protocol with regional health centres and by a teacher-training initiative focusing on issues such as health promotion, counselling, sexual education and contraception.

Health and psychological counselling services in universities in Portugal are still somewhat limited. These services face numerous obstacles, such as lack of economic and institutional support, scarce human resources and the absence of a formal framework of government-recognized support services for higher education students. Guidelines for psychological support services for higher education students were set out in Parliament Resolution 71/2000, dated 7 November 2000, which addresses the need for interventions on risk factors and behaviours among teenagers and youth.

A variety of organizational models for youth-friendly health services (YFHS) provision exists within national health services in Portugal. At primary care level, municipalities have specific health services for youth supported by local health centres, youth centres and activity from independent organizations. In relation to adolescent-friendly specialized care in paediatric units, the adolescent outpatient clinic at Hospital

de Santa Maria in Lisbon is a pioneering unit that was established in March 1996 as the first such clinic inside a department of paediatrics in the country. Its development reflected the recognition of a complete lack of such health services in the country at the time.

Given the successful experience with the Hospital de Santa Maria, Portugal is currently in the process of reorganizing health care services with the aim of creating conditions for universal adolescent attendance at departments of paediatrics. While there are still limitations in adolescent health care resources in Portugal, not only in relation to structural conditions but also in specific professional training and the availability of appropriately trained professionals, other relevant innovative initiatives are under way in the country; these are cited at the end of the case study.

Youth health and health education – context

Adolescents are to some extent a group who fail to engage with medical services. Health services that attempt to specifically address the needs of adolescents began in the 1980s through the national education and health systems. This process is not complete, however, with a range of different and not completely integrated organizational models evident in health services (emergency services, adolescent units and primary health care) and the education system (including school health, university health and counselling services and health education).

The most prevalent cause of mortality in young people in Portugal – road traffic accidents – is the same as that of other European countries. Portugal, however, has a relatively good record in relation to mortality in young people due to road traffic accidents, with chronic diseases (diabetes, epilepsy, asthma and cardiopathologies) being more frequent reasons for seeking medical care during youth.

The plano nacional de saúde juvenil (PNSJ) [national youth health plan] included in the national health plan of 2006 specified youth health, including treatment of, and interventions for, adolescents as a priority. The plan includes:

- physical and human resources;
- logistics; and
- staff training as general practitioners, paediatricians, gynaecologists, nurses, social workers, nutritionists and exercise scientists.

Hospital facilities include:

- beds adjusted to adolescents' dimensions
- gender-separated bedrooms
- academic supervision and leisure facilities
- a holistic approach, minimizing bureaucracy
- staff trained in non-discriminatory practice
- measures to reduce waits in waiting rooms
- a special focus on empathy and confidentiality.

Education is compulsory until the 9th grade in Portugal (this will be extended to the 12th grade in 2009/2010). Average dropout rates are 36%, and average grade retention is 10% in 1st to 6th grade and 20% from 7th to 9th grade. Many measures are in place to prevent both school dropout (including the programme “New opportunities” and economic incentives to families) and retention (special educational programmes, remedial teaching, special needs education and special support) rates.

In terms of economic status, fewer than one third of adolescent pupils have one parent with a university degree. Students who attend a public university have access to social services that include housing facilities, health services and psychotherapy and counselling services.

Both health and education systems have specific protocols with other agencies devoted to youth services. These include:

- different structures within the Ministry of Health;
- schools and universities;
- the Instituto Português da Juventude (IPJ) [Portuguese Institute for Youth];
- recreation associations;
- sport associations;
- musical and performance arts organizations;
- municipalities;
- nongovernmental organizations (NGOs) in the area of sexual health, adolescent pregnancy, family violence, poverty, minorities, disadvantaged youth and HIV/AIDS; and
- cultural institutions.

Priorities in youth health in past years have tended to concentrate on biological issues (immunization, physical development monitoring, screening for infectious diseases, dental health, nutrition and ophthalmic and audio screening). More recently, a focus on nutrition, physical activity and prevention of substance misuse, unplanned pregnancy, STIs and interpersonal violence has emerged, with an emphasis on encouraging small but sustainable steps towards a healthier lifestyle. This involves the development of personal competences and promoting youth participation and the involvement of peers, family and teachers.

According to the WHO Health Behaviour in School-aged Children (HBSC) study, Portuguese children aged 11–15 years can be considered “average” in the Europe context in relation to substance use, sexual health, nutrition, physical activity, mental and physical well-being and relationships with friends. They are above average in fruit intake and in not missing breakfast, but have a lower classification in relation to school well-being, school stress and perception of school competence. Other international studies (such as the Programme for International Student Assessment (PISA) study and the Innocenti Report Card) confirm aspects of these findings, but they also distinguish Portuguese youth as having better family and peer support compared to many other countries.

Parliament approved Law 3/84 on “The right to sex education and family planning” in 1984. This law was further regulated through Dispatch 52/85, which exhorted health centres to create youth-friendly health services (YFHS). The law and the dispatch ended the requirement for parental consent and enabled every viable youth (that is, those who had achieved reproductive function) to access family planning consultations. This remains the legal framework underpinning YFHS, with young people’s confidentiality being protected through the application of established clinical guidelines by health care staff (doctors, nurses, psychologists and social workers).

Health promotion in schools and collaboration with national agencies

In 2005, the Ministry of Education decided to change health education in Portuguese schools into a regular, sustainable process. It created a working group, the Grupo de Trabalho para a Educação Sexual/ Educação para a Saúde (GTES) [Working Group on Sexual Education/Health Education] to present proposals to ensure by 2007 countrywide coverage of a schools curriculum that included health. The GTES team started work in June 2005, and their proposal, subsequently accepted into public policy and law, prescribed that health education would be a priority that would be compulsory in schools across all subjects, and called for students’ and parents’ active participation.

From 1st to 9th grade, health education should be included:

- across all school subjects, explicitly in each “class project”, and evaluation; and
- as part of national curriculum provision in four areas: “Project area”, “Tutored study”, “Citizenship education” and “School option”.

It was proposed that at least one of the four areas would be devoted to health education and at least one hour a month would focus on sexual education. Health education should involve all students, calling for their active participation with the aim of developing knowledge, autonomy, responsibility, individual choices and social participation.

Four main health issues for priority intervention were identified:

- substance use
- sexuality/STIs and HIV prevention
- nutrition and physical activity
- violence prevention and mental health and well-being.

Portugal has been involved in the European Network of Health Promoting Schools (ENHPS) since the 1990s and is now part of its successor network, Schools for Health in Europe (SHE), but national policy now requires every school to conform to health promotion standards. Additionally, it was recommended for all schools (mandatory in secondary schools) that a health cabinet, “Health space”, be created. This is a place in the school in which pupils can be individually seen and supported by a reference teacher or health professional supplied by the local health centre. A number of schools are now developing this concept.

Following GTES recommendations, Law 995/2005 of 16 December 2005 stated that health education should be compulsory in schools and that a teacher in every national school should be nominated as the “health coordinator”. There is now a school education plan in each school that includes health education for all and defines schools as health-friendly environments. Pupils, guided by a teacher, must explore subjects related to mental health, environmental education or sexuality on a weekly basis and must dedicate a minimum of one hour every month to acquiring other competences, such as those associated with gender equity and ethics.

From 2007 to 2009, the proportion of schools which provided health education rose from 79% to 95%. In 2009, 43% of schools had a “Health space” addressing health issues with pupils, and 83% had a youth club focusing on cultural, sports and leisure issues (which may also include health topics).

The Direcção-Geral de Inovação e de Desenvolvimento Curricular (DGIDC) [Director-General of Innovation and Curricular Development] held a competition in 2009 aimed at preventing violence in schools. This is intended to become an annual event. Around 250 schools were included and 500 projects were taken forward by 1000 pupils. Specific teacher training was also included.

Another DGIDC competition run in close partnership with the national agency against HIV was also launched in 2009. This one aimed to encourage debate in schools on preventing STIs, particularly HIV: 216 projects were submitted and awards were granted. Again, this is now an annual event.

Law 60/2009, which gives statutory support to public policies on health promotion in sexual education in schools (nationally compulsory from 1st to 12th grade), was approved on 6 August 2009. This law sets out that in 2010, all schools will have a “Health space” where students can voluntarily access confidential health care and counselling. These “spaces” will operate within schools’ jurisdiction and will be supported by a protocol with regional health centres and by a teacher-training initiative focusing on issues such as health promotion, counselling, sexual education and contraception. Partnerships involving the DGIDC and other public structures, institutions and organizations have been arranged. These are outlined in the following section.

National platform against obesity

The national platform against obesity (<http://www.plataformacontraaobesidade.dgs.pt>) is supported by the Ministry of Health and runs roadshows for schools aiming at promoting healthy lifestyles, exercise and healthy and balanced nutrition.

Alto Comissariado da Saúde – Plano Nacional de Saúde [High Commissioner for Health – National Health Plan]

The High Commissioner for Health (<http://www.acs.min-saude.pt>), in collaboration with the Ministry of Education, regularly promotes meetings and debates for young people.

National Agency against HIV/AIDS

The competition “Learning to prevent HIV/AIDS” reflected a strategy developed in coordination with GTES policy which aimed to challenge students and teachers from basic and high schools to develop materials to promote HIV/AIDS prevention.

Submissions were evaluated for their originality, content, communicative prowess and applicability. Currently, the National Agency against HIV/AIDS (<http://www.sida.pt>) is preparing a travelling exhibition of the 24 best submissions from the schools that participated in the competition. The aim of the exhibition is to promote healthy lifestyles and prevent STIs through a range of dynamic activities presented in schools for a week.

National agency for sports

The Instituto de Desporto de Portugal (IDP) [Sports Institute of Portugal] (<http://www.idp.pt>) is currently implementing two major projects specifically designed for Portuguese schools. The main objective is raising awareness of the importance of lifestyle changes and positive health promotion through increased physical activity and involvement in sport.

The IDP also takes an active part in intersectoral national projects addressing problems such as drug abuse and addiction and their relationship to physical and mental health, within the wider scope of sports training. In addition, IDP works with GTES and the Faculdade de Motricidade Humana (FMH) [School of Human Kinetics] to provide every school with an instrument to assess fitness that also includes guidelines for interventions, and for intervention evaluation, in the area of physical education.

National agency for drug prevention

Young people constitute an increasingly important group for the national agency for drug prevention, the Instituto da Droga e Toxicoddependência (IDT) [Institute for Drugs and Drug Dependency] (<http://www.idt.pt>). The IDT produced an action plan for 2004 to 2012 which presents selective interventions focused on at-risk vulnerable groups that aim to complement universal interventions applied by schools, municipalities and youth centres. An information system that allows monitoring and evaluation of interventions has been created.

IDT’s focused intervention programme aims to promote ways of developing evidence-based national projects in addiction prevention. The projects must meet the problems of specific groups by including a rigorous and structured system of quality criteria in selection, monitoring and evaluation processes. The specific objectives of the programme are to develop selective preventive interventions for children and vulnerable youth and individuals who use psychoactive substances in recreational settings. The programme also promotes specific skills to cope with risks associated with the use of psychoactive substances and aims to develop interventions for families.

The regional IDT community-based integrated project is a multidisciplinary resource located in Porto that is implemented and maintained by IDT local services. Its main goal is to provide a clinical counselling facility for children and young people in collaboration with locally available services. The technical team includes psychiatrists, psychologists, sociologists and social workers.

Several clinical activities have been developed to cover a number of strong indicators. The clinical responses offered to children and young people include not only first consultations, but also psychological evaluation, forensic examination, school-based initiatives and municipal interventions. The goals are to:

- create a physical environment in which children and young people can access specialized counselling (this clinical resource approaches the family as a whole);
- provide information to the community and promote training for young people on specific skills to deal with the risk and decrease prevalence;
- encourage professionals to monitor interventions with vulnerable groups in the community;
- promote and collaborate in scientific projects supported by universities and schools, among others; and
- provide systematic training for, and monitoring of, the team of professionals.

The national IDT plano operacional de respostas integradas (PORI) [operational plan for integrated responses] is a structural measure that highlights accurate diagnosis, which is fundamental to the development of a field intervention. PORI has sequential phases and is achieved through the creation of programmes of integrated responses in each identified territory. The programmes of integrated responses specifically integrate interdisciplinary and multisectoral interventions related to some or all areas of the IDT mission (prevention, treatment, harm and risk reduction and reintegration), depending on the diagnoses results of a territory identified as a priority.

The national diagnosis put in place in 2006/2007 led to the identification of 163 territories in continental Portugal where an integrated intervention on drug use was needed. The national diagnosis was developed by IDT local and regional structures in partnership with about 900 public and private entities. The WHO rapid assessment and response methodology was chosen for the diagnosis of each selected territory, which allowed a comprehensive assessment to be made in a short period of time.

With the diagnosis, it was possible to identify needs that had not been met in the territories. To fulfil these needs, IDT offered technical and financial support to projects from NGOs. Fifty-one programmes of integrated responses will be implemented in 2009 to meet 124 identified needs in several areas, mainly prevention. Fifty-two prevention projects are in progress, mainly concerning youth people in settings such as schools, recreational contexts and in the streets. The projects are developed by an NGO which is supported technically and financially by IDT, with the monitoring and evaluation functions carried out by a group of institutions which directly or indirectly participated in each programme. These include local authorities, schools and local primary health services.

Another 24 programmes will be implemented in 2010, dealing with 31 identified needs in several areas; 18 of these are prevention projects.

Health in universities

Psychological counselling services in higher education in Portugal are still somewhat limited (*1*), as they face numerous obstacles such as the lack of economic and institutional support, scarce human resources and the absence of a formal framework of government-recognized support services for higher education students. Guidelines for psychological support services for higher education students were set out in Parliament Resolution 71/2000, dated 7 November 2000, which addresses the need for interventions on risk factors and behaviours among teenagers and youth.

Counselling services focus on promoting personal development, risk prevention and interventions on clinical issues. These services address (individually or in groups) multiple and complex problems, such as:

- personal and developmental issues
- issues related to self, health and well-being
- stress and anxiety in the academic context
- study skills and time management strategies
- interpersonal relations
- entrance into employment
- psychopathological issues.

Consulting and supervision activities are also valued and pursued in some of these services.

Counselling services may be attached to university departments, to psychology departments of higher education institutions, to the main structure of universities (dean's office or academic services) or to their social services. The majority are fully financed by the host institution, but some generate their own income through consultation fees, training fees or research-related income.

Despite their diversity, counselling services in higher education institutions share common goals, such as:

- supporting the academic community in the promotion of students' physical and psychological well-being;
- promoting student personal and social development; and
- promoting health in the academic community, with an emphasis on student health.

Psychological counselling has been developed using different approaches, the most common of which are dynamic therapies, behaviour and cognitive-behaviour interventions, social skills training and the construction of social support networks.

Psychological support services in higher education networks

Psychological support services in universities have tended to include several models and intervention techniques. Their structure varies according to the institution, staff training and personal dynamics. Because of this and a desire to encourage cooperation, mutual support and resource optimization, the idea of organizing a network that would include all such services arose.

The network started in 2000 under the name Rede dos Serviços de Aconselhamento Psicológico do Ensino Superior – Associação Profissional (RESAPES –AP) [Psychological Support Services in Higher Education Networks – Professional Association] and was officially established through law published in the Official Journal on 17 January 2005.

RESAPES –AP focuses on the strengthening of counselling services in higher education through providing staff training and by promoting efforts to enlarge the network. It aims to promote experience exchange, mutual support and cooperation on training and scientific approaches, and to support integrated action on the definition of frame sets, financing and staff and in the construction of a common identity and ethical code.

Youth-friendly health services in the national health service

There is a variety of organizational models for youth-friendly health services provision within the national health services.

Youth-friendly health services at primary care level

Municipalities have specific health services for young people that run alongside local health centres, youth centres and independent facilities. Regional administrations of health include health centres with specific youth-friendly services: some of these services offer a simple extra facility for youth (such as reproductive health consultations and free access to contraceptives), but others are far more sophisticated and include several specific facilities (immediate access to consultations and an integrated health approach from a multidisciplinary team, for instance).

Schools now have a specific partnership with local health centres to promote school health following the signing of a protocol by the Ministry of Education and the Ministry of Health in 2005. The Directorate of Health has a web site which maps health services for young people that are delivered in collaboration with schools (<http://www.dgs.pt>).

Health service teams work with teachers on school health issues in the nondisciplinary areas of the national curriculum. This work is focused on sexual education, substance use, nutrition, physical activity, violence prevention and mental health. Interventions are always carried out in partnership with teachers and involve all pupils, calling for their active participation and aiming to develop their knowledge, autonomy, responsibility, ability to make choices and social participation.

Adolescent-friendly specialized care in paediatric units

Adolescent outpatient clinic

The adolescent outpatient clinic was established in March 1996 in the Department of Paediatrics at the Hospital de Santa Maria. It was the first such clinic to be established inside a department of paediatrics in the country and was developed as a result of the recognition of a total lack of global, adolescent-friendly health services in the country at the time.

An interdisciplinary team from three departments (paediatrics, gynaecology and psychiatry) was built to concentrate resources in one clinic, enabling adolescents to access adequate responses to their health care needs without having to look for answers throughout the complex maze that the hospital represents to a young person. The team consists of two full-time senior paediatricians with expertise in adolescent medicine, one full-time senior psychologist, one senior gynaecologist, one nurse and one social worker.

To date, we have provided training in adolescent medicine and health for 45 paediatricians, 25 psychologists and 9 family doctors. The goals of the training are to:

- provide a global adolescent health care approach;
- develop a curriculum in adolescent health care both at undergraduate (last two years of medical school) and postgraduate levels, including paediatric residents, family doctors and psychologists;
- provide continuing education sessions on adolescent health to general practitioners at the Lisbon subregional health department;
- work with health care centres within the hospital's geographic area;
- deliver educational and information sessions to schools, whenever requested;
- provide postgraduate training to paediatric residents who have compulsorily rotated within the clinic since 1996;
- respond to the training demands of paediatric residents and paediatricians of other hospitals by assuming the role of a reference centre; and
- facilitate practical training experiences for general practitioners, nurses and psychologists in other regions of the country.

When a young person comes to the clinic, he or she is seen by a paediatrician who will assume responsibility for the case. If the assessment indicates that specialized care is required, this will be discussed at the weekly interdisciplinary team meeting. After the meeting, if it is considered that additional support is needed, an appointment will be scheduled for psychiatry, psychology or gynaecology.

The weekly team meetings provide an opportunity for the team to work in an interactive way, to present cases and to discuss the most interesting ongoing situations. Over time, the meetings have developed into a "school" in which knowledge and experiences are shared. Monthly meetings that are open to professionals from various fields and training sessions focusing on "HEADSSS" (home and peers; education; activities; drugs; safety; sex; suicide) interview and family therapy techniques have been held over the past four years. The team has also started to work in different preventive programmes with community-based institutions, such as "What makes you healthier?", "Learning to improve your self-image", and "Obesity prevention".

The clinic was open three times a week for two hours in the afternoon during its first two years, but has been open five days a week between 09.00 and 17.00 since 1999. There was consequently a 36% increase in the number of consultations between 1998 and 1999, corresponding to an increase of 20% in the number

of adolescents seen. Resources have been stabilized over the last three years and the clinic has seen a slight increase in the numbers of first-time visits and follow-ups.

The exponential rise in demand seen during the clinic's first four years has now stabilized, largely due to the integrated working that has been developed with health care centres situated within the geographical area of the hospital; investment in this initiative was one of the clinic's main priorities. In addition, the training sessions the clinic organized covering the main adolescent health topics, and the discussion and supervision that was carried out, may also have contributed.

In 2008, 1712 consultations took place (219 first consultations and 1493 follow-ups). Patients were mainly referred by family doctors, the paediatric emergency service, other units of the paediatric department, other departments in the hospital and schools. There was a predominance of females aged 11–16 years; the fact that fewer patients aged above 16 years attended may be due to the clinic being perceived as being part of a "paediatric" department.

The six most-common reasons for clinic attendance were: behavioural disorders; learning disabilities; disordered eating, including obesity; family dysfunction; gynaecological problems; and growth-related issues.

The high prevalence of obesity led to the development of a programme specifically for obese teenagers in 1998. This programme is very different from the traditional way of dealing with obese teenagers. It is peer- and family-based and uses cognitive and behavioural techniques as well as specific family interventions.

Most adolescents present with specific problems that reveal diagnostic and intervention challenges. The interdisciplinary intervention model adopted by the clinic provides an excellent opportunity for integration of physical and psychosocial approaches and represents an innovative approach to clinical intervention in Portugal.

The fact that the clinic is within the university campus and is located in the same building as the medical school facilitates a permanent rotation of medical students, residents and other health professionals. This has greatly enhanced the educational perspective within the clinic and has proved a real incentive for the clinic to become a highly specialized learning centre.

Portuguese Youth Institute holiday camps

Due to the alarming number of obese youngsters in Portugal, the Portuguese Youth Institute has sought to provide holiday camps for young overweight people, in partnership with the Hospital de Santa Maria.

The holiday camps aim to encourage regular physical activity and healthy eating and to promote healthy and responsible lifestyles. An activity programme that includes sports, entertainment and healthy eating workshops is offered to allow the young people to explore healthy choices and gain access to personal consultations.

Camps have been held in July 2008 and July 2009. Sixty young people aged between 10 and 16 years participated, followed by an obesity consultation session at the hospital. By the end of the camps, the young people had each lost an average of 2.25 kg (girls 2.485 kg., boys 1.985 kg.). The partners are planning to develop other innovative intervention strategies against obesity.

Scaling-up a successful experience⁷

Given the successful experience within the Hospital de Santa Maria, Portugal is currently in the process of reorganizing health care services with the aim of creating conditions for universal adolescent attendance at departments of paediatrics. Our objective here is to evaluate the actual adolescent health care facilities in Portuguese hospitals within departments of paediatrics.

⁷This section is adapted from the abstract and tables of a paper submitted and accepted by *Acta Pediátrica Portuguesa* by Tavares and Fonseca, co-authors of this case study.

A questionnaire was sent to all Portuguese hospitals with departments of paediatrics. Of the 55 questionnaires distributed, 45 were returned. These showed that the mean age of attendees was 18 years for outpatient clinics and 15 years for inpatient clinics and emergency rooms.

Eighteen departments of paediatrics reported having an adolescent outpatient clinic. Half of these had a specific attendance area and 17% a specific waiting room. All of them reported having social service support, 94% had a nutritionist, 89% a psychologist, 83% a gynaecologist and 61% had psychiatrist support. Only 50% reported getting support from all of these different professionals. Five departments of paediatrics reported being in the process of planning an adolescent outpatient clinic in 2008.

Ten adolescent inpatient clinics with a total of 56 beds were reported, predominantly distributed in the Centro and Lisboa/Vale do Tejo regions (70%). In the total sample, 276 beds with appropriate adolescent dimensions were reported, most of them concentrated in the Centro and Lisboa/Vale do Tejo regions (71%). Seventeen departments of paediatrics had professionals with specific training in providing inpatient adolescent health services. Six reported having only one observation room and one reported the lack of beds of appropriate dimensions for adolescents in the emergency room.

The survey shows that there are still some limitations in adolescent health care resources in Portugal that concern not only structural conditions, but also specific professional training and the availability of the different kinds of professionals that should ideally be part of the multidisciplinary team.

A summary of some of the findings from administrative health regions taking part in the survey is presented in Table 1.

Table 1. Administrative health region findings

| Region | Total hospital units | Total hospital unit respondents | Total adolescents * | Total adolescent outpatient clinics | Total adolescent inpatient clinics |
|-----------------------|-----------------------------|--|----------------------------|--|---|
| Norte | 18 | 11 | 428 545 | 6 | 3 |
| Centro | 14 | 13 | 241 885 | 4 | 3 |
| Lisboa e Vale do Tejo | 14 | 10 | 274 444 | 5 | 3 |
| Alentejo | 3 | 3 | 70 671 | 1 | 0 |
| Algarve | 2 | 2 | 41 090 | 1 | 0 |
| Madeira | 1 | 1 | 30 825 | 1 | 0 |
| Azores | 3 | 3 | 33 962 | 0 | 1 |
| Total | 55 | 43 | 1 121 422 | 18 | 10 |

* 10–19-years-old, based on Instituto Nacional de Estatísticas (INE) [National Institute of Statistics] (<http://www.ine.pt>) census data, 2007

Project-based initiatives

Mental health

Despite the prevalence of mental and behavioural disorders, it is estimated that between 15% and 20% of child and adolescent mental health services are still unsatisfactory, with a low frequency of preventive programmes, limited responses to vulnerable groups and low participation among families and service users.

The national health plan for 2004 to 2010 considers mental health a priority and allocates funds for infant, child and adolescent mental health as part of public policy. Primary (mental) health care is addressed in the national plan and the reorganization of mental health services (including those for adolescent mental health) has been taken forward by the Ministry of Health, but the following limitations are still apparent:

- a lack of child psychiatrists and psychologists in primary care
- no national epidemiological studies, only occasional surveys regarding inpatient clinics
- services tend to be provided by NGOs and private agencies
- young people are not regularly involved in the organization of medical services.

Núcleo de Estudos do Suicídio (NES) [Centre for the Study of Suicide]

NES is a multidisciplinary team within the Department of Psychiatry in the Hospital de Santa Maria. It receives young people from 11 to 21 years who exhibit suicidal behaviours, such as suicide attempts, suicidal ideation and self-harming behaviours, and bases its approach on a systemic intervention model which includes the individual and family and, if necessary, the social network (school, community, general practitioner and others).

An assessment, without prior appointment, is offered to provide quick and urgent care for adolescents and/or family members who attend. The assessment involves collecting data on the risk of suicide, the characteristics of any suicide attempt, the presence of psychiatric disorder and psychopathological symptoms within the adolescent, any current family problems and an evaluation of social support.

“Jovens à Terça” (JOTER) [“Youth on Tuesdays”]

This young people’s mental health initiative is taken forward under the Centro Integrado de Tratamento Ambulatorial e de Reabilitação (CiNTRA) [the Integrated Centre for Outpatient Treatment and Rehabilitation]. It aims to promote mental health and resilience by working closely with schools and teachers and by offering teacher training and weekly psychotherapy groups with young people. Difficult or complex situations are referred for individual psychiatric or psychological consultation.

The initiative has an established partnership with health centres and juvenile protection committees. Proposed objectives were reached by around 80% of the young people attending JOTER groups. Support from the Directorate for Health and a partnership with the Ministry of Education will be required if it is to be sustained in the future.

“Aparece” [“Step in”]

Based on an extension of a local health centre (Lapa), “Aparece” (<http://www.arslv.t.min-saude.pt/projectos/ProgramasEspeciais/Paginas/Aparece.aspx>) is an adolescent primary health care service for all young people aged 11–24 years living in the Lisbon area. It was created in 1999.

The initial contact with the service is with a nurse who then refers the young person to a doctor. The doctor can either manage the young person or refer on to an expert within 10 days. The service is free of charge, involves little administration and aims to ensure short waiting times. It is based in the model of primary care centred in family medicine/adolescent medicine.

A multidisciplinary team (doctors, psychologists, nutritionists) work in the service and address youth health issues in a holistic way, focusing on health topics such as sexual health, substance use, nutrition and lifestyles and integrating all relevant actors (family, peers, teachers). “Aparece” works in conjunction with schools, health centres, hospitals, NGOs, universities, student units and family and juvenile court remedial and rehabilitation institutes.

“Espaço S” [“Area S”]

Based as extension of a local municipality (Cascais), “Espaço S” [“Area S”] (<http://www.geracao-c.com/Espaço-S.aspx?ID=880>) is a primary health care adolescent health service for all young people aged 11–24 years living in Cascais area.

The service is free of charge, involves little administration and aims to ensure short waiting times. It is based in the model of primary care centred in family medicine/adolescent medicine. A multidisciplinary team (doctors, psychologists, nutritionists) work in the service and address youth health issues in a holistic way, focusing on health topics such as sexual health, substance use, nutrition and lifestyles and integrating all relevant actors (family, peers, teachers). “Espaço S” works in conjunction with schools, health centres, hospitals and NGOs, and the municipality of Cascais has other adolescent-friendly sport, leisure, culture and education initiatives that work with “Espaço S”.

Global preventive care: Portuguese Youth Institute

The Portuguese Youth Institute has sought to provide a diversified, multidisciplinary service for youth health and sexuality that meets young people’s needs and combats misinformation.

Four projects have been created:

- the “Sexualidade em linha” [“Sexuality on line”] telephone helpline
- youth health and sexuality counselling services
- a youth online portal on health and sexuality
- the “Cuida-te!” [“Take care!”] programme.

“Sexualidade em linha” [“Sexuality on line”]

In January 1998, due to its experience in providing services for young people, the Portuguese Family Planning Association (see below) was approached by the youth state secretary with a view to organizing a helpline on sexuality. The telephone helpline “Sexualidade em linha” [“Sexuality on line”] has now been running since 1 June 1998. It is a national information, counselling and support service on sexual and reproductive health developed as a result of a partnership between the Portuguese Youth Institute and the Family Planning Association, a partnership that still exists.

The helpline is anonymous and confidential and its main goals are to:

- promote informed choice
- contribute to the adoption of responsible personal and social behaviours
- stimulate young people to preserve and promote their own health
- promote healthy lifestyles.

The helpline received more than 10 000 phone calls from youth in its first year of activity and provided information on a wide range of sexual and reproductive health issues. To date, more than 150 000 calls have been answered by the association’s team of counsellors.

Youth health and sexuality counselling services

Youth health and sexuality counselling offices are, as their name implies, places where young people can meet sexual and reproductive health counsellors who will try to answer their questions. The service is free of charge, anonymous and confidential.

Counselling offices have been developed as the result of partnerships with local health ministry delegations, hospital administrations and other partners with proven experience in this area. Their purpose is to fill the void in this kind of service for young people by providing easy access to information about sexual and reproductive health and the development of the body during adolescence and by offering services from a qualified multidisciplinary team.

Online youth portal

The Portuguese Youth Institute provides an online youth portal (juventude.gov.pt) on health and sexuality where doubts and questions about health and sexuality can be raised in an anonymous and confidential way with a professional team of advisers. It is not necessary for the young person to give any contact details,

even an e-mail address; each individual is provided with a code when posing a question that enables him or her to access an answer. The approach creates a “virtual” service, adapted to the needs and characteristics of young adolescents.

“Cuida-te!” [“Take care!”]

The “Cuida-te!” programme aims to educate young people about health by promoting the acquisition of knowledge and skills in this area in a global and integrated way and by interconnecting different health elements: somatic, psychoemotional and social. Action areas are:

- promoting global health for young people;
- promoting regular physical activity, healthy eating and healthy and responsible lifestyles;
- preventing consumption of hazardous substances; and
- promoting sexual and reproductive health by targeting young people (between 12 and 25 years), teachers, parents, association leaders, health professionals and others working in this area.

Associação de Planeamento Familiar (APF) [Family Planning Association]

The Portuguese Associação de Planeamento Familiar (APF) [Family Planning Association] (<http://www.apf.pt>) was first involved in youth-friendly services at the beginning of the 1980s with two small counselling and information services located in Coimbra and Lisbon. Both services were linked to family planning consultations in hospitals in these two cities. No youth-friendly services existed within the national health service or among other service providers at that time.

The APF opened the Lisbon service as a response to a dispatch from the Ministry of Social Affairs (which had responsibility for health services at that time (1981)) that restricted access of youth under 18 years to family planning consultations without parental written consent. The association launched a campaign against this dispatch in 1981/1982 and organized a “Commission for the right of youth to contraception”. The campaign strengthened the links between the APF and schools and maintained public debate on the issue.

In 1986, following an International Planned Parenthood Federation European Network (IPPF EN) project on youth-friendly services, the APF Porto branch, in partnership with Porto Regional Health Administration, organized the first “centro de atendimento de jovens” (CAJ) [youth attendance centre] in the town (“CAJ Batalha”). This project integrated the design and organization of training curricula on youth-friendly services for health professionals, including issues such as adolescence, sexual and reproductive health, counselling and communication skills, with regular supervision. The Porto service still exists.

New CAJs were subsequently organized in partnership with the APF in several communities in the north of Portugal; in 2008, these centres received more than 2500 young people.

Training for health professionals was provided in all the APF regional branches. Trainers were also invited to integrated training programmes with general practitioner training schools. Counselling and information services were maintained in the other APF branches and new partnerships on youth-friendly services were built in some municipalities in the Lisbon region. These services and partnerships have been sustained and still exist.

APF work in youth-friendly services was recognized by the Ministry of Health and both institutions celebrated an agreement in 1997 that includes the issue of youth-friendly services.

New APF projects have started in local communities across several regions of the country and are being developed in community settings. They are specifically directed towards marginalized youth groups, with new work focusing on teenage mothers and their partners. In Matosinhos near Porto, the association is involved in community work with Roma youth.

APF involvement in youth-friendly services is strongly linked to its work on sex education activities in schools, training of teachers and other community professionals and the production and dissemination of educational resources. The association continues to provide training courses for health professionals on youth-friendly services through its training centre.

The health of at-risk children

The Instituto de Apoio à Criança (IAC) [Child Care Institute] (<http://www.iacrianca.pt>) is a private social welfare institution that represents powerless children who have no “voice” by being the voice of their needs. It works to try to help children have a happier childhood.

The “Projecto rua” [“Street project”] is a department of IAC that was devised in 1989 to address the issue of the vast number of children living by themselves, roaming and sleeping in Lisbon’s streets. “Projecto rua’s” current goal is to contribute to the reduction of the number of children in at-risk situations, promoting family and social rehabilitation.

“Projecto rua” intervenes in the following areas:

- children in the street
- education and training
- support of communities
- social networks.

“Projecto nacional de educação pelos pares” [“National peer-education project”]

The “Projecto nacional de educação pelos pares” [“National peer-education project”] (<http://filomena.tx.googlepages.com/funda>) was developed by the Foundation Community against AIDS through youth counselling centres in schools and youth rehabilitation centres. The project’s aim is to promote understanding of sexuality and prevent HIV infection. It focuses on health promotion in schools by training peers to be volunteers in schools and in the community.

“Aventura social” [“Social adventure” project]

Based in the Technical University of Lisbon and integrated in FMH (a school that is devoted to health promotion, exercise science, performing arts, sports and physical education) and in partnership with the Centre for Malaria and Tropical Diseases, “Aventura social” (<http://www.fmh.utl.pt/aventurasocial>) is a youth-friendly service related to research. It includes contributions from a number of psychologists and is involved in collaborations with several international networks, including:

- HBSC (<http://www.hbsc.org>) (collaboration on youth lifestyles, risks and protective behaviours);
- Kidscreen (<http://www.kidscreen.org>) (quality of life in children and families);
- TEMPEST (Temptations to Eat Moderated by Personal and Environmental Self-regulatory Tools) (<http://www.tempestproject.eu>) (macroenvironmental threats to health and personal self-regulation competences);
- “Peer drive-clean” (<http://www.peer-projekt.de/>) (preventing substance use and driving);
- DICE (Drama Improves Lisbon Key Competences in Education) (<http://www.dramanetwork.eu>) (drama as a method of increasing competences and education); and
- “Peer-mentor support” (<http://www.peermentor.org>).

The “Aventura social” team develops a set of selective interventions with at-risk adolescents and universal interventions for schools and communities within disadvantaged migrant communities around Lisbon. The team also held a juvenile consultation (university based) within the context of a project called “Health promoting universities” which targeted university students aged 17 to 25 years. It is part of the network of

psychological support and counselling initiatives addressed to university students (see above) and includes not only individual consultations that are free of charge, but also cultural initiatives, debates, special interest groups, focus groups, workshops and self-help groups.

An interactive web page has been designed for young people containing health information and interactive materials (<http://www.aventurasocial.com>). This was considered “best practice in mental health for youth”.

“Aventura social” has developed a peer-mentoring support programme, including a mentors’ training programme. It has also developed a set of procedures around selection, training, matching, supervision and needs assessment for individual mentoring plans which has been developed and tested in different European countries as part of the Leonardo programme of the European Union. This involves working with peers acting as positive agents of change and engaging young people at risk of social exclusion in education, vocation and the labour market. A peer-implementation programme within a current action research initiative has developed a bank of personal development resources and a training model for peer mentors to enable them to create individualized personal development programmes for young people.

Conclusions and lessons learnt

- Adolescents are not children, but neither are they adults – physically, psychologically or socially.
- In Portugal, the national health plan incorporates physical and human resources, logistics and staff training (general practitioners, paediatricians, gynaecologists, nurses, psychologists, social workers, nutritionists and exercise scientists).
- Hospital facilities must address young people’s needs by having: beds adjusted to adolescents’ dimensions; gender-separate bedrooms; academic supervision and leisure facilities; a holistic approach, minimizing bureaucracy; staff trained in non-discriminatory practice; measures to reduce waits in waiting rooms; and a special focus on empathy and confidentiality.
- Health education is a priority in Portugal and is compulsory in schools across all subjects, involving students’ and parents’ active participation. Health education should be included across all school subjects from 1st to 9th grade and explicitly in each “class project” and evaluation. It is part of national curriculum provision in four areas: “Project area”, “Tutored study”, “Citizenship education” and “School option”. Four main health issues for priority intervention have been identified: substance use; sexuality/STIs and HIV prevention; nutrition and physical activity; and violence prevention, mental health and well-being.
- Specific services (sexuality, birth control, drug use, nutrition, etc.) need to focus on addressing adolescents’ need for anonymity. Adolescents fear being recognized by neighbours or friends of their parents when accessing services.
- Adolescents are intimidated by bureaucracy. Forms, authorization procedures and the recording of family clinical histories should be kept as brief as possible.
- Services’ waiting areas should ensure that adolescents are not waiting alongside much younger children, or much older young people.
- Health professions should be trained to listen to adolescents, to offer effective holistic care, to be trustworthy and to expand their focus beyond physical health issues or obvious health complaints.
- Psychological counselling has been developed and implemented within all universities, addressing university students’ well-being during the transitional period of entering the university, which is a time characterized by great vulnerability.
- The need to link health promotion, primary care and specific health care to high-level research activity at universities has been highlighted, with collaboration needed on systematic evaluation of interventions and practices, action research and youth participation.
- Special care needs to be exercised in addressing inequalities associated with issues such as gender, ethnicity, migration status, poverty, poor schooling, social discrimination and belonging to a minority community.

Reference

1. Pereira A. Psychological counselling in higher education – an overview of Portuguese reality. *Newsletter of the Division of Counselling Psychology of the International Association of Applied Psychology*, 2009, 5:8:17–20.

The Republic of Moldova: evolution of health care services in schools

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Executive summary

At the beginning of the 2007/2008 school year, primary and secondary comprehensive education was provided in 1534 schools in the Republic of Moldova, with 461 000 pupils enrolled. Three quarters of the total number of schools operate in a rural environment.

Respiratory diseases rank first in school pupils' morbidity (31%), with diseases of the eye (10.2%) second, digestive diseases (9.7%) third and disorders of the central nervous system (8.5%) fourth. Disorders of posture are the most common musculoskeletal problems in pupils. Accidents, intoxications and traumas are at present the major cause of mortality among the young, and problems with sexual and reproductive health, substance misuse and mental health problems are becoming more common.

At present, the law on health care stipulates the level of provision of health care services in schools. Standards for health care workers at pre-university education institutions are laid down under a joint order of the Ministry of Education and Ministry of Finance published in 1999. Model regulations for the position of health care worker are governed by a joint 2002 order of the Ministry of Health and Ministry of Education. Job descriptions for school health service (SHS) personnel are governed by the model regulations for the position of the health care worker. Nurses' duties consequently include keeping records on pupils' morbidity levels and reporting these to local preventive medicine centres. The model regulations also cover the nurses' responsibility for inspecting pupils' study conditions and regularly checking compliance with sanitary conditions at school canteens.

The national programme of compulsory health insurance provides for annual preventive medical examinations of all children, school pupils included, performed by family physicians. At the age of 3, 7, 11 and 15 years, the children have a comprehensive medical examination from specialists, as required.

At the present time, the Republic of Moldova is developing policies, laws, strategies and government resolutions enabling the development of the SHS to an appropriate level. This case study describes the processes involved in the development of SHS in the Republic of Moldova, the challenges that remain, and the long-term actions that need to be taken to ensure an effective SHS into the future.

Socioeconomic and cultural context

Demographic data

The population of the Republic of Moldova, as of 1 January 2008, was 3 572 700, with 41.3% living in urban settings and 58.7% in rural areas. The population breakdown in terms of gender is 51.9% women and 48.1% men. Children up to 18 years account for 22.8% of the population and young people make up 28%.

The labour force migration phenomenon in the Republic of Moldova, as in all post-Soviet states, has had a substantial negative impact on population growth and on the overall social and economic structure of the country. As many as 7% of families have at least one member who has emigrated. More than 25% of those who have emigrated (men and women) have left children behind. Approximately 37% of migrants from urban areas and 45% from rural left at least one child behind, and 20% of migrants left two or more children (*1*).

Integration of school-age children in the education system

At the beginning of the 2007/2008 school year, primary and secondary comprehensive education was provided in 1534 schools in the Republic of Moldova, with 461 000 pupils enrolled. This is 6.2% less than in the previous school year and 26.7% less than in the 2000/2001 school year. Three quarters of the total number of schools operate in a rural environment.

Primary and secondary comprehensive education is provided at several types of institution:

- 6% of children are in primary schools
- 44% are in gymnasia
- 19% are in comprehensive secondary schools
- 29.5% are in lyceum schools
- 2% are in schools for children with deficiencies in mental or physical development.

There has been a reduction in some types of secondary comprehensive education institutions over the last five years subsequent to a review of the independent status of schools, following which many institutions have either been dissolved or have been absorbed into other types of school operating at different levels of education.

Ninety-four per cent of children receive primary education and 90.1% gymnasium education. Significant differences are observed in terms of residence, with the gross rate of coverage for primary education in urban environments being 10% higher than rural. Respective proportions for gymnasium education are 95.4% urban and 87.3% rural. Gender coverage differences between primary and gymnasium education are insignificant.

Almost all pupils in primary and secondary comprehensive education (99%) are enrolled in public schools, the private sector still being insignificantly represented. The 4200 pupils enrolled in private schools reside in urban areas. French language is studied predominantly by children in rural settings, with those in urban environments studying English.

Some schools continue to operate with the education process organized in two shifts. The proportion of pupils, studying in the second shift has dropped over recent years to only 2.6% of the total number of pupils.

The number of pupils enrolled in special education in the 2007/2008 school year dropped by 6.1% from the previous school year. Most of these pupils (79.3%) suffer from mental development disorders and 7.2% have poliomyelitis-related disorders and cerebral palsy. In addition, 6.1% have poor hearing, 3.3% are deaf, 2.9% have poor eyesight and 1.2% suffer from behaviour disorders (2).

Children have an opportunity to continue their studies at secondary vocational and specialized secondary education institutions on graduation from comprehensive education institutions.

Cultural context

Approximately 85% to 90% of the population of the Republic of Moldova are Orthodox Christians. Religion is a school subject at public education institutions.

The promotion of a healthy lifestyle, including sexual education, is a priority in the national health policy (3). Special manuals on “life skills” have been developed to enable pupils to implement healthy lifestyle principles at education institutions. Life skills is an optional subject; attempts to introduce the subject into school curricula have failed due to negative reactions from many parents.

Priority health and development needs of school-age children in the Republic of Moldova

General morbidity

Data produced by the National Scientific and Practical Centre of Preventive Medicine in 2009 show that respiratory diseases rank first in school pupils' morbidity (31%), with diseases of the eye (10.2%) second, digestive diseases (9.7%) third and disorders of the central nervous system (8.5%) fourth. A reduction in the level of general morbidity was registered in 2008 compared to 2007. Disorders of posture are the most common musculoskeletal problems in pupils. The morbidity of posture disorders in pupils in pre-university institutions has remained at roughly the same levels, amounting to 12.3% in 2007 and 12% in 2008.

The levels of morbidity from endocrine diseases (19%) and nutritional and metabolic disorders (19.3%) were unchanged between 2007 and 2008. The most frequent endocrine pathologies and nutritional and metabolism disorders in pupils at pre-university institutions were obesity and thyroid gland and related disorders caused by iodine deficiency.

Accidents, intoxications and traumas

Accidents, intoxications and traumas are at present the major cause of mortality among the young. Statistics from the National Health Management Centre in 2007 showed that these causes accounted for over 50% of deaths of young people.

Sexual and reproductive health

The incidence of sexually transmitted infections (STIs) in adolescents has not shown any tendency to decrease over the last decade and is currently approximately 30% higher than in the general population. Adolescents (10–18 years) account for 10.3% of HIV-infected people in the country. Consistent growth in the incidence of HIV among adolescents has been registered since 2003, along with growth in the sexual transmission rate of the virus.

Adolescent pregnancy rates are rather high and show no signs of decreasing. Between 80% and 90% of pregnancies among adolescent girls are unwanted and end in abortion or abandonment of the baby after birth. The rate of post-abortion complications exceeds 30%.

According to the knowledge, attitudes and practices survey of young people regarding their health and development (4), 22.8% of young people between 10 and 24 years claim to have had sexual relationships, with an average age at first sexual contact of 16 years. Only 8.3% replied correctly to all questions about the spread and prevention of STIs and HIV.

The use of protection methods among the young was limited. Only around one third of young people who had already had sexual intercourse used condoms for every sexual act. Young people consequently face the risk of problems associated with sexual activity, such as STIs and unwanted pregnancies.

Young people stated that they would like to be better informed about health and sexuality by their parents and other informed adults (such as physicians and psychologists). The survey points out that health care services are available in most of the country's communities, but the young do not access them because they are not perceived as user-friendly in terms of qualitative, confidential and age-related issues. Although almost 80% of the young respondents had had health problems during the previous year, only 37.7% consulted a physician about those problems.

Abuse of psychoactive substances

Addictive behaviour among the young (abuse of alcohol, tobacco and drugs) constitutes a sociomedical problem of increasing importance. Several representative national surveys, including the Global Youth Tobacco Survey, have revealed that around 75% of young people between 15 and 17 years state they have smoked over recent years, and 32.7% of them smoke regularly. Although the prevalence of boys' smoking is slightly higher than girls', gender differences are less than 5%.

Based on statistical data and opinion polls, we can surmise that 8 out of 10 families face problems related to alcohol or intoxicating substance abuse that may be severe enough to cause family and interpersonal violence. Around 80% of registered crimes are committed by people intoxicated by alcohol or acting under the influence of alcohol or other substances. A 2005 opinion survey showed that 54.4% of minors and adolescents consumed alcohol to forget their troubles, 42% drank to relax and 39.8% drank to follow their friends' example. Almost a third (31.8%) mentioned following their parents' example and observing family traditions.

Most minors and teenagers have acknowledged awareness of the fact that drugs harm their health, but some continue to exhibit risky behaviours, causing numerous problems. Drug addiction statistics for adolescents are shown in Table 1.

Table 1. Drug addiction in adolescents, 2001–2006

| Year | Registered number of adolescents suffering from drug addiction | Numbers of children of up to 15 years |
|------|--|---------------------------------------|
| 2001 | 313 | 16 |
| 2002 | 307 | 11 |
| 2003 | 252 | 12 |
| 2004 | 221 | 8 |
| 2005 | 318 | 15 |
| 2006 | 388 | 18 |

Source: Republic Narcology Centre

Mental health

A growth in the incidence of mental and behavioural disorders in children under 18 years has been seen in recent years (485.6 per 100 000 in 2005 and 602.86 per 100 000 in 2006). Nonpsychotic conditions (neurosis, organic cerebral disorders and behavioural disorders) rank first (74.2%).

In 2006, 2811 children with a degree of disability were registered with paediatric psychiatrists, making up 22.22% of the total supervised contingent. A degree of disability was newly diagnosed in 329 children, most of whom have mental retardation (5).

Violence and child trafficking

According to statistical data from the international centre "La Strada", around 25% of the victims of human trafficking they assist are people under 18 years.

Nutrition

Table 2 shows the prevalence rates of some nutrition-related diseases in children aged 0–17 years and Table 3 shows the equivalent incidence rates.

Table 2. Rate of prevalence of some nutrition-related diseases in children aged 0–17 years in the Republic of Moldova (eastern districts not included)

| | 2006 | | 2007 | | 2008 | |
|---|---------|-----------------------|---------|-----------------------|---------|-----------------------|
| | Numbers | Per 10 000 population | Numbers | Per 10 000 population | Numbers | Per 10 000 population |
| Retardation in physical development due to malnutrition | 3 802 | 46.7 | 4 132 | 49.8 | 3 595 | 44.9 |
| Obesity | 2 222 | 27.3 | 2 146 | 25.8 | 2 182 | 27.2 |
| Anaemia | 31 840 | 391.0 | 32 867 | 395.8 | 32 328 | 403.7 |

Table 3. Rate of incidence of some nutrition-related diseases in children aged 0–17 years in the Republic of Moldova (eastern districts not included)

| | 2006 | | 2007 | | 2008 | |
|---|---------|-----------------------|---------|-----------------------|---------|-----------------------|
| | Numbers | Per 10 000 population | Numbers | Per 10 000 population | Numbers | Per 10 000 population |
| Retardation in physical development due to malnutrition | 1 178 | 14.5 | 1 463 | 17.6 | 1 158 | 14.5 |
| Obesity | 584 | 7.2 | 536 | 6.5 | 582 | 7.3 |
| Anaemia | 16 144 | 198.3 | 17 429 | 209.9 | 16 629 | 207.7 |

Adaptation and the “order of the day”

A survey performed between 2000 and 2003 by the National Scientific and Practical Centre of Preventive Medicine revealed that 56.3% of first-grade pupils adapted well to school, 29.9% had a medium degree of adaptation, and 13.8% of pupils adapted poorly (mainly due to lack of maturity, chronic diseases or syndromes such as attention deficit hyperactivity disorder).

Pupils’ adaptation to the education process is also negatively influenced by non-observance of the daily regimes. Analysis of the degree of observance by first-grade pupils indicates that pupils sleep and spend less time outdoors and watch television for prolonged periods. As many as 2.3% spend no time outdoors whatsoever, and another 11.6% do so for only an hour a day. As many as 19.8% do not eat breakfast at home or only take breakfast occasionally, and only 49.6% have their breakfast at school.

A significant number of pupils exhibit emotional stress and anxiety. A low level of work capacity can be observed during the year in 11.5–17% of pupils. The publication of exam results causes an intensification of negative tendencies in some pupils’ state of health. At schools which operate in two shifts (2.6% of schools), duration of breaks of just five minutes (7.1% of schools), lack of sports groups (22.4%), lack of sports facilities (28.2%), poor quality of published manuals and the amount of sedentary time contribute to poor mental health.

Infectious diseases

Tuberculosis is a significant problem for pupils. The number of tuberculosis incidents among school-age children increased from 1.6 per 100 000 in 2000 to 25.8 per 100 000 in 2007. Incidents of drug-resistant tuberculosis emerged in children in 2007. Tuberculosis also occurs among the personnel employed in schools.

Background, recent reorganization initiatives and current organization of health care services at schools in the Republic of Moldova

Legislative and regulatory framework

At present, the law on health care stipulates the level of provision of health care services in schools. Standards for health care workers at pre-university education institutions are laid down under a joint order of the Ministry of Education and Ministry of Finance published in 1999. Model regulations for the position of health care worker are governed by a joint 2002 order of the Ministry of Health and Ministry of Education (Appendix 1). It has been a long process to develop the current legislative and regulatory framework; some statutory acts are under revision to be brought into line with amendments recently made to the legislative framework (see below).

Infrastructure

Only 75.8% (1139) of pre-university education institutions have specific medical facilities. Health care workers are often accommodated in the school office or in other facilities that do not comply with current requirements. Over 85% of medical stations at education institutions do not have essential medical equipment and have incomplete supplies of emergency medication, creating a risk for pupils and employees.

Staff and duties

School nurses provide care to pupils and employees throughout their stay at the education institution. Duties performed by health care personnel are aimed at ensuring the institution operates in compliance with hygiene standards, can provide emergency health care to pupils and can contribute to illness-prevention activities. Health care personnel work with education sector colleagues, including teachers, during infectious disease incidents (hepatitis A, influenza, intestinal infections etc.) at the education institution. School nurses organize recreation camps for pupils in the summer and arrange for annual medical examinations. Currently, sanitary services at schools are provided by specialist nurses who have graduated from nursing schools. Enrolment is undertaken by the school director.

The Ministry of Education submits an official application order to the Ministry of Health annually requesting health care staffing of education institutions appropriate to local needs. Nursing schools are financed by the state budget through the Ministry of Health and the nursing school assigns nurses to schools upon graduation, with the involvement of representatives from the Ministry of Health. In addition, school directors employ nurses independently based on personal applications.

Basic professional training of nurses at nursing schools follows a national curriculum approved by the Ministry of Health and the Ministry of Education. The professional skills specific to the work of school nurses are enhanced at refresher courses held under the auspices of the nursing schools. In compliance with statutory acts, nurses, including school nurses, must attend such refresher courses at least once every five years. Certification for the purpose of determining the qualification category (I, II, or III, where “I” is the most experienced and “III” the least) is performed every five years by the Commission on Certification of Nurses.

Nurse employees of schools find themselves permanently on the school's premises, unless they are involved with local health care institutions in activities such as scheduling vaccinations and attending joint seminars.

The number of pupils at schools, particularly in rural areas, has dwindled considerably over the past 10 years, as has the birth rate. As salaries are linked to the number of pupils, nurses working at many village schools may receive half or even quarter the standard salary, which may result in a decrease in the amount and quality of health care services provided to pupils.

Job descriptions for school health service (SHS) personnel are governed by the model regulations for the position of the health care worker shown at Appendix 1. Nurses' duties consequently include keeping records on pupils' morbidity levels and reporting these to local preventive medicine centres. The model regulations also cover the nurses' responsibility for inspecting pupils' study conditions and regularly checking compliance with sanitary conditions at school canteens. This includes supervising the technology related to food preparation, the use of iodine-enriched salt and calculation of the nutritional value and caloric content of food.

The national programme of compulsory health insurance provides for annual preventive medical examinations of all children, school pupils included, performed by family physicians. At the age of 3, 7, 11 and 15 years, the children have a comprehensive medical examination from specialists (paediatrician, ophthalmologist, ear, nose and throat specialist, surgeon, neurologist, psychiatrist, dentist and speech therapist), as required. Screening tests widely used within the framework of such examinations are not always cost-effective, particularly due to the lack of an adequate referral system, but include tests for foot problems, faults in posture, reduced visual and hearing acuity and problems in physical development.

Background to health care services in schools

The SHS was established in the Republic of Moldova during the 1960s and 1970s as part of the Soviet Union five-year plans, with orders issued by the Soviet Ministry of Health. The major goal pursued in several statutory acts and orders issued during this time was to establish health care services in schools that would offer prevention services and dispensary health care to pupils, immunization, nutrition and supervision of sanitary conditions. Special subdivisions, "school/pre-school units", were established within the framework of municipal children's polyclinics and district children's clinics. These employed school physicians (paediatricians) and school nurses enrolled in compliance with national personnel standards. The Ministry of Health of the Republic of Moldova has taken over these statutory acts entirely and they are now absorbed within a ministerial order.

Attention was initially paid to eyesight problems, preventing infectious diseases and trauma and organizing pupil examinations prior to sending them to work camps, recreation camps or career guidance activities. School health care workers were charged with promoting the physical development and strength of children through promoting sports and healthy lifestyles. A special programme on hygiene education and self-help for illness and trauma was launched in the 1980s under the heads of municipal health care departments and head physicians of district hospitals.

A joint order of the Ministry of Health and Ministry of Education in 1989 described the major problems in pupils' health and in the quality of health care services provided at schools. The order raised for the first time the issues of sexual education for pupils, prevention of alcoholism, drug addiction and smoking and the promotion of healthy lifestyles. It also tackled the problem of professional training of health care personnel employed at schools with a proposal to submit a petition to the Council of Ministers of the Soviet Socialist Republic of Moldova (SSRM). The annex to the order contained an approved model list of medical equipment and medications for school health care consulting rooms and heads of health care institutions were instructed to include

specialists such as psychologists and career guidance experts among the staff of the school/pre-school units.

The order was abrogated by another joint order of the same ministries in 1995. Annexes to this order approved for the first time:

- requirements for health care workers at education institutions
- hygienic requirements and standards for organizing training at schools
- delivery of an annual report on provision of health care to pupils
- annual certification of schools.

The requirements for health care workers at education institutions stipulated the duties of school physicians and nurses, with analysis of morbidity in school pupils and reporting of morbidity rates being introduced to the duties of health care workers.

The 1995 order was abrogated and replaced in 2002 by another order from the education and health ministries, which is still in force. This order is named “On health care of pupils at pre-university education institutions and measures of improvement”. It describes a change in the source of remuneration for health care workers, now provided by local public authorities.

Reforms in the health care system and their impact on the organization of SHS

The health care system has faced major financing problems since the Republic of Moldova became independent in 1991. The economic crisis has had a strong impact on the availability of funds. After a drastic drop in gross tax revenue, consequent budget reductions were not distributed evenly among all sectors. Health, education and social protection ceased to be considered priorities so received only “residual” funding; this actually meant that funding was allocated to these areas only after the fundamental budget sections were provided for. Public health expenditure reduced by approximately 62%, reaching a per capita level of only US\$ 10 per year.

Chronic underfunding has meant a substantial decrease in access to health care services for people with low incomes and the emergence of the phenomenon of “direct payment”. A high number of families with low incomes have given up on health care because of lack of money. Funding assigned to the health care system was used inefficiently, while tertiary-level hospitals were supported. Only 20% of the total value of health care expenditure was assigned to services provided to 80% of patients in primary health care.

Due to the simultaneous underfunding of the education system, the SHS was reduced to providing only immunization services and compulsory annual pupil medical examinations. A considerable exodus of health care personnel from schools took place. Consequently, efforts were made at central public authority level to reform the system, with primary health care transformed by establishing family physician centres and offices, closing district hospitals and consolidating the emergency health care service.

Nurses have been gradually introduced to education institutions in rural settlements, particularly in schools, since 1990 by virtue of a resolution of the Council of Ministers of the SSRM . Municipal and district councils were entrusted with the role of funding education institutions, including schools. Funding of health care workers at schools located in rural settings was provided through local education budgets, while those in schools located in urban areas (Chisinau, Balti and some district centres) were funded from the health care system by means of the school/pre-school units that still operated within family physician centres. There was therefore a rural/urban discrepancy in terms of funding agents.

This situation persisted from 1992 to 2005. Education law underpinned the organization of health care services at schools. Article 59, “Health care at education institutions”, stipulated that:

“The health care institutions of the Ministry of Health and the departmental health care institutions ensure the performance of the entire range of measures aimed at protecting the health of pre-schoolers, pupils and students as well as the health of the teaching personnel in the education system.”

However, a joint order issued by the Ministry of Health and Ministry of Education in 2002 asserted that schools nurses be employed and remunerated by education institutions.

The situation was aggravated with the transition to compulsory health insurance in 2004. This transition augured well for positive evolution in many aspects. Mobilization of resources to, and the procurement mechanisms of, provider services improved, and financial contributions increased; indeed, the consolidated health care budget increased threefold between 2002 and 2007. Children under 18, including adolescents, pregnant women, full-time students of education institutions and some other categories benefit from health insurance free of charge, at the state’s expense.

The transition to compulsory health insurance has also, however, generated unforeseen consequences and severe repercussions for the SHS. At certain times, their very survival has been endangered. The national health insurance company, which funds all services, provided funding for remuneration of primary health care employees only through family physician centres, which did not include SHS. The question therefore emerged as to who was going to finance school nurses, and the health insurance company made it categorically clear that it did not view this as its responsibility. It justified this stance by suggesting that family physicians provided a comprehensive service from which school pupils benefited entirely at the expense of the state. Every family physician, it explained, had to include in his or her team either three (in rural settings) or two (in urban) nurses per 1500 population on his or her list, in compliance with standards approved by the government.

The description that now follows deals with service reorganization which, following the initial funding injection, has been extended to other elements of the SHS.

Reform of funding of the SHS in the Republic of Moldova

Compulsory health insurance was introduced in January 2004. From this time, primary health care for all population groups in local areas, including school pupils, has been provided by family physicians and family physician assistants, in compliance with measures stipulated in the national programme.

The provisions of the legislative and statutory acts in force and the framework of compulsory health insurance made it clear that medical personnel would not be maintained at schools through the funds of compulsory health insurance; instead, it was proposed that all activities performed by school-based health care workers be carried out by the family physician and his or her team.

This approach had at least two limitations. One was that the organization of annual preventive medical examinations of children differed from area to area, depending on the availability of the family physician. While the examination in some localities was performed in compliance with Ministry of Health standards with participation from the family physician, in other areas with no family physician the examination amounted to some screening tests performed by nurses. Limiting the SHS to the involvement of family physicians therefore reduced opportunities for children living in disadvantaged communities to access health care services.

The second limitation was that family physicians were unable to meet all children’s health care and development needs, including issues related to sexual and reproductive health, adaptation problems and mental health.

In this context, the Ministry of Health and Ministry of Education saw that having health care workers based in schools would be necessary to maintain the health of the growing generation. It was proposed to use local budgets to introduce health care worker roles at those schools which did not previously provide for such positions. The Ministry of Education argued for the pressing need to develop (or at least maintain) health care services at every school, building on requirements set out in the law on education.

A joint meeting of the ministries in January 2006 focused on the state of pupils' health and health care in the national education system. The need to improve health care services provided at schools and the issue of supplying education institutions with medical personnel were highlighted during these discussions. At the same time, it was resolved to review the standards for school nurses.

The Ministry of Health was compelled by the courts to comply with the requirements of the law on education, which states that all health care services provided to children need to be ensured and financed by the health care system. This meant that the health care system should have taken over the funding of nurses in rural schools. The Ministry of Health then undertook a detailed comparative analysis of health care services provided at schools and the national programme of health care services approved by government and financially covered by the health insurance company. Building upon that analysis, the Ministry of Health was able to demonstrate to all courts two important factors that have determined further reform of the SHS.

First, that there is an entire suite of health care services at schools that are not included in the single programme and which consequently did not appear on the list of the services reimbursed by the health insurance company, meaning separate funding out of the budget was required.

Second, it was able to demonstrate that school nurses were contributing to the education process and the monitoring of pupils' health, thereby justifying the remuneration of health care workers by local public authorities.

These conclusions allowed the Ministry of Health to propose amendments to the Law on Health Care No. 177 of 20 July 2007 by adding to Article 51, Chapter VI.1 (Box 1).

Box 1. Amendments to Article 51 of the Law on Health Care No. 177 of 20 July 2007

Article 51.1: Additional quality services provided to children, pupils and students at education institutions.

(1) Additional health care services are provided to the children, pupils and students at education institutions, in addition to the care provided within the framework of compulsory health insurance, and special destination national health care programmes.

(2) The nomenclature of additional health services provided to children, pupils and students at education institutions is to be developed by the Ministry of Health jointly with the Ministry of Education, and to be approved by the Government.

(3) Additional health care services are provided to children, pupils and students by the health care personnel of education institutions, in compliance with the standards approved by the Government; the expenses are borne by the budgets of education institutions.

From funding reform to reform of the SHS paradigm

Enforcing the amendments to Article 51 included detailing the additional health services to be provided to pupils and students at education institutions, a task that was entrusted to the Ministry of Health. This offered an opportunity to develop the list of relevant services so that it not only covered the historical list, but also reflected best practice at international level.

WHO Regional Office was requested to support this effort, enabling the Ministry of Health to set up a workshop with a national team of experts and stakeholders in January 2008. Participants at the workshop gained insight into the experience of other countries in organizing and reorganizing the SHS, including the transition seen in several countries in recent decades of moving from a health care paradigm to a social care paradigm. They also explored the results of evaluations of the efficiency of some traditional SHS interventions and critically analysed practices in the Republic of Moldova. Participants analysed the functional duties of physicians and nurses within secondary education, as stipulated in the model regulations of health care workers (Appendix 1), and saw that only a very small part of those duties were dedicated to the promotion of health or to providing positive interventions on sexual and reproductive health, mental health and other acute childhood problems.

The workshop not only generated recommendations on the list of services, but also raised other important aspects of SHS organization, such as having:

- a supportive regulatory environment
- a system of referral between the SHS and community services
- systems to evaluate and monitor SHS quality
- systems to address capacity-building and professional identity of SHS workers (Box 2).

Box 2. Workshop on Reorganization of School Health Services and Referrals for Adolescents' Health and Development: Chisinau, Republic of Moldova, 21–23 January 2008

RECOMMENDATIONS FOR NEXT STEPS

Using existing resources, linkages with and integration into ongoing programmes and initiatives

SHS have a role to play in contributing to adolescents' health and development. However, school-age children's well-being depends on a larger context of socioeconomic determinants and is not constructed in the school setting only. In order that governmental efforts in all settings are complementary, SHS should use existing community resources and make linkages with and contribute to priorities of ongoing relevant programmes, strategies and initiatives. The reorganization of SHS should build upon, and contribute to, the general government efforts to improve the quality and expand the coverage of health service provision to adolescents. For instance, setting a quality improvement for SHS mechanisms should be made complementary and coherent with national standards for youth-friendly health services.

Participation

Establish a mechanism of active participation of school-age children at all stages of situation analysis, planning, implementation, monitoring and evaluation of the process of the reorganization of the SHS in the Republic of Moldova.

Ensure that [school nurses are widely represented and] involved in the reorganization process

Revision of the relevant regulatory framework

In order to remove barriers to the effective performing of new tasks and create a supportive regulatory environment, it is recommended to review the existing regulatory documents that influence SHS.

Capacity building

New job description implies a change of paradigm in service provision, from medically oriented to health promotion. This will demand the revision of existing training programmes. It is recommended to consider designing and putting in place a specialization training course in SHS for new entrants into the service, and review the continuing medical education curricula

according to the new job description.

Profession identity

Participants at the workshop pointed out that currently, school nurses are disadvantaged in many aspects compared to medical staff working in health institutions. For instance, school nurses are not united within a professional association; they do not have a network of information sharing, experience exchange, tutorial supervision and support. It is therefore recommended to initiate a forum in which school nurses can discuss and decide the form of professional organization that would best serve their interest. As a possible option for supervision and tutorial support, participants suggested that the Deputy for Maternal and Child Health in the primary health care unit in rayon [a territorial-administrative unit, analogous to “district”] could be the best person to assure continuous support and supervision of school nurses from the given rayon. The fact that technical supervision is provided by health authorities, while administrative supervision can be the prerogative of school administrations, should be made clear in updated regulations.

Documentation

Participants at the workshop identified that revision of the job description of school nurses would change not only the way services are delivered, but would also imply system changes in other functions of the health system – stewardship, resource generation and financing. It is therefore recommended that new experiences are carefully monitored, evaluated and lessons learnt are adequately taken into consideration during the process of reorganization.

The workshop also produced a draft of the additional health services provided to children, pupils and students at education institutions which was later finalized by the national team and approved through Government Resolution No. 934 of 4 August 2008 (Box 3).

Box 3. Additional health care services provided to children, pupils and students at education institutions, as approved by Government Resolution No. 934 of 4 August 2008

Section 1

Services of prevention

Ensuring the organization of activities of observance of the sanitary epidemiologic standards at the institution, in compliance with the requirements of the statutory acts in force, and monitoring thereof:

- by checking medical certificates on the state of health and immunization of children, pupils, students and employees, accompanied by the required measures;
- by means of early and active identification of those infected with transmissible diseases and medical supervision of those who have contacted with contagious patients;
- by organization and evaluation of performance of the measures aimed at preventing the transmission of contagious diseases through common factors: drinking water, foodstuffs, food cooked at the institution’s food processing unit;
- by organizing and performing current disinfection during the persistence of niduses of contagious diseases in the collectivity;
- by organizing and performing, jointly with the primary health care service and the preventive medicine service, of examinations of children in order to detect helminths and conduct treatment;
- by carrying out examinations to detect pediculosis;
- by keeping records and submitting statistical reports.

Organization of information support in the process of immunization of children, pupils and students at the institution.

Monitoring and supervision of performance at the institution:

- of physical training activities;

- of the nutrition of children, pupils and students;
- of observance of the order of the day of training and recreation;
- of observance of anti-epidemic conditions.

Section 2

Health care services

- Provision of first aid in the event of an emergency.
- Participation in conducting the preventive examinations performed at the educational institution.
- Individual information and communication with every child, pupil and student having special needs, as their personal needs may be.
- Organization and performance of measures of promotion of the health of children at the institution.

Section 3

Education for health

1. Organization and performance of activities of information and education in health promotion and development of children, pupils and students for:
 - prevention of traumas, accidents, intoxications and violence;
 - improvement of mental health and psychological wellbeing;
 - prevention of incidents of tuberculosis, sexually transmitted diseases, HIV-infection, unwanted pregnancies among adolescents;
 - prevention of consumption of harmful substances (alcohol, tobacco, drugs);
 - promotion of rational nutrition (reduction of malnutrition, obesity, iodine and iron deficiency etc.);
 - promotion of physical training activities.
2. Development of information bulletins on disease prevention and distribution among pupils, students, parents and teachers of information materials edited within the framework of communication campaigns in the areas of healthy lifestyle promotion.
3. Organization and performance of activities of information, education and communication with the parents about the improvement of the children's health and development.
4. Organization and performance of trainings for pupils, students and the teaching personnel about the provision of first aid in the event of emergency.
5. Active and effective involvement of pupils and students in scheduling, performing, monitoring and evaluation of measures of activity support.

Section 4

Creating a supportive environment

(work with health care institutions, parents and community)

1. Cooperation with superior level health care services and other community services dealing with the health and development of children, pupils and students.
2. Cooperation with community members (local public administration authorities, police, economic entities, NGOs) for enhancing the safety of the environment at the educational institution and in the community.
3. Correct referral of children, pupils, students and parents, upon application, to superior level health care services and other community services.

Unresolved issues

At the present time, the Republic of Moldova is developing policies, laws, strategies and government resolutions enabling the development of the SHS to an appropriate level. As the *National health policy of the Republic of Moldova 2007–2021 (3)* puts it:

“State security and sustainable development of society are to be attained, among other things, by means of maintaining and improving the health of the young generation, through a partnership

between the public administration authorities (central and international structures), community, civil society and the international structures.”

The fact that strengthening of the primary health care service remains a priority for the health care system in the Republic of Moldova is also a supporting factor for further SHS development. Primary health care is often the first point of contact for adolescents with the health care system. In this context, clearly defined, sustainable strategies have been developed on family medicine, separating primary health care finances from hospital institutions, reinforcing the material and technical infrastructure of buildings and providing medical equipment. Implementation mechanisms, however, have not yet been fully put in place.

The character of the health care problems teenagers face has undergone multiple changes, mainly related to behaviour and access to services to meet their needs, and in the emergence of “new” problems such as HIV, drug addiction, alcohol misuse and trauma. Despite this, the responsibilities and authority of SHS have not changed a great deal. The SHS has remained unchanged for a long time and consequently does not meet pupils’ priority needs for health care and development.

The requirements of the additional services outlined in Box 3 are only being partially fulfilled at present. The methodology of adopting individual approaches with every pupil and teacher and working with families is underdeveloped, and there is practically no cooperation with the community and social services. No referral mechanism for pupils who need to access other services is in place. There are signs, however, that cooperation with primary health care staff and preventive medicine services is being progressed efficiently.

SHS quality differs between institutions and is affected by the environment (rural or urban), the provider (public or private) and the employed personnel (qualified or unqualified). Indirect evaluation mechanisms of SHS are:

- the level of compliance with health regulations at the education institutions; and
- the incidence and prevalence levels of infectious diseases and food poisoning among pupils of different schools.

There are currently no specific indicators that would enable an accurate evaluation of SHS quality. Under Government Resolution No. 934 of 4 August 2008, the Ministry of Health must ensure the evaluation of the quality of additional health care services provided to pupils at education institutions.

The fact that school nurses are subordinated in administrative terms to the school director and in functional terms to the local family physician in rural settlements or deputy head physician in urban settlements (on matters of mother and child health) means that staff in preventive medicine centres are unclear about what services the nurses can offer. Nurses’ links to the education sector, including with teachers, are evident in managing infectious disease incidents, in organizing recreation camps for pupils in the summer, in physical training, and in organizing annual medical examinations, but cooperation with teaching personnel is less-well developed in relation to settling pupils’ individual problems or in strengthening health education, specifically in urgent areas such as prevention of HIV infection, alcohol misuse, unwanted pregnancies among adolescent girls and drug addiction. The referral mechanism is limited to sending pupils to health care institutions for medical examinations and counselling.

Relationships between the SHS and the community, local public administration and health care centres are limited and evaluation and monitoring of SHS quality is restricted to annual reports on pupils’ morbidity levels, results of medical examinations and the quality of nutrition. It is necessary to review the form of reporting and evaluation of the SHS by integrating self-evaluation tools and

quality indicators that would meet pupils' current needs.

The SHS in public education institutions is entirely funded from the state budget through the education system. The funding is limited to the remuneration of health care personnel and purchase of medications and consumables. Medical equipment is often limited and out of date.

The supply of nurses has become a serious problem for the health system, including the SHS. The main reasons nurses leave their posts or do not apply for posts upon graduation are low salaries and lack of housing. The salaries of nurses at health care institutions contracted by the national health insurance company have increased substantially in recent years, and the exodus of health care personnel from those institutions has reduced. Remuneration for SHS staff comes from a budget that is much lower than that of the institutions financed by the national health insurance company, meaning that education institutions have experienced health care personnel shortages of 25–30%, over the last five years.

In-service training opportunities for school nurses are limited because of poor planning and referral by the education institutions. The training course curriculum for school nurses should be revised to introduce topics that would meet the requirements of the additional health services provided to pupils.

Provision of medication to the SHS is undertaken in compliance with an approved list, but this list needs to be standardized to ensure that medication provision does not differ between schools.

Long-term actions

Long-term actions are connected to current unresolved problems.

In relation to **establishing a supportive regulatory environment**, it will be necessary to review and update the mechanism of Government Resolution No. 934 by means of developing:

- regulations for SHS organization
- regulations on SHS quality control and quality indicators
- the methodology of cooperation between the SHS and other local services
- the scheme of referral of pupils to other services.

It is crucial to **outline a mechanism enabling the SHS to contribute to the implementation of national programmes and strategies in the area of young people's health**. One of the priorities of the national reproductive health strategy, approved by the government in 2005, is adolescents' health. The Ministry of Health has made proposals to the government to approve a plan to improve pupils' health over the years 2009–2011 which includes measures to:

- maintain and strengthen the conditions under which young people are educated
- identify and prevent risk factors
- promote physical activity
- promote activities aimed at nurturing respectful behaviour towards health values.

These activities are aimed at encouraging a healthy lifestyle and promoting physical and mental health.

The national concept of youth-friendly health care services (YFHCS) was approved through a resolution of the Board of the Ministry of Health and Social Protection, Report No. 11, of 29 November 2005. The Ministry of Health continues to develop YFHCS, with 12 centres having been established within family physician centres. YFHCS are being financed from compulsory health insurance fees through separate contracts with each centre. Personnel and service quality standards

and guidance on the organization of a multidisciplinary team to provide a comprehensive approach to adolescents' problems were approved in 2008 to regulate the centres' operation.

The health care system has developed a legislative framework that provides a context for addressing the problems of young people, but the mechanism for implementing the legislative acts remains underdeveloped. SHS potential has therefore yet to be enacted fully and practical means of involving school health care personnel in supporting young people to address the numerous challenges they face have not yet been found.

As far as **capacity creation and formation of professional identity of SHS personnel** is concerned, it has been decided to revise the basic curriculum and the in-service curriculum for nurses by including additional teaching on issues related to the implementation of the additional health services provided to pupils in education institutions. A mechanism for health care personnel registration, certification and involvement in various activities related to the health of pupils and adolescents needs to be developed, with certification processes being specific to work performed at schools. An incentive scheme for SHS personnel and means of enhancing the prestige of the profession also need to be created and nurtured.

In relation to **organization of SHS provision**, it is necessary to review hygiene requirements and school medical equipment. It is essential to create comfortable conditions to enable health care personnel to conduct private and confidential consultations with pupils. Existing employment arrangements do not allow health care employees to work full time in around 50% of schools in villages, which hinders SHS development. These arrangements need to be reviewed to enable most schools to employ health care personnel full time.

SHS in public institutions are financed from the local budget by means of the education system. It will be necessary to monitor and evaluate the impact of this funding method on SHS quality, including its impact on staffing levels, opportunities for further training and other elements that have suffered in the past due to ambiguity over SHS funding.

References

1. *Moldova demographic and health survey*. Chisinau, National Centre of Public Health and Management, 2005.
2. *Children of Moldova*. Chisinau, National Bureau of Statistics of the Republic of Moldova/UNICEF, 2008.
3. *National health policy of the Republic of Moldova 2007–2021*. Chisinau, Ministry of Health, 2008.
4. *Young people's health and development: national baseline evaluation of the knowledge, attitudes and practices of young people*. Chisinau, UNICEF, 2005.
5. *Public health care in Moldova in 2006*. Chisinau, Ministry of Health and Social Protection, 2007.

Appendix 1. Model regulations for the position of the health care worker

1. Health care of pupils can be provided by family paediatricians and hygienists, by health care personnel having secondary education and special training.
2. School physicians must possess knowledge in the field of child hygiene, paediatrics and epidemiology.
3. School physicians shall be guided in their activity by the directives and methodological documents of the Ministry of Health of the Republic of Moldova, and are subordinated to school directors and (being employees in the school personnel arrangements) to the manager of the territorial family physician centre.
4. The main task of the physician consists in organizing and conducting preventive, sanitary, anti-epidemic, and health care measures at schools. School physicians work in cooperation with territorial health care institutions, the Centre of Preventative Medicine, school administration and the children's parents, as members of the school teachers' meeting.
5. Duties of the physician:
Physicians must:
 - 5.1. Work under a plan approved by the school administration and territorial health care institutions.
 - 5.2. Organize and perform the preventive examination of pupils, evaluate their state of health based on the medical examination's results, and fill in [form] specific recommendations as to the patients' rehabilitation and health improvement, determine health and medical groups for physical training, receive patients and prescribe proper treatment, examine the pupils before immunization, detect actively contagious and parasitic diseases, undertake preventive measures against tuberculosis.
 - 5.3. Perform the analysis of the medical examination results, of training conditions of the pupils, and jointly with the experts of the centre of preventive medicine (which under the order no. 69/42 of 1 February 1995, were named as "centres for hygiene and epidemiology") develop a plan of specific actions to protect the pupils' health. The plan is to be approved by a local public administration authority (mayor or council), the school director and the manager of the family physician centre (named "territorial health care institution" following the order no. 69/42 of 1 February 1995) and to be coordinated with the centre of preventive medicine.
 - 5.4. Monitor the implementation of health care and preventive aspects in:
 1. organization of physical training activities;
 2. organization of pupils' nutrition;
 3. undertaking anti-epidemic measures;
 4. observing the pupils' order of the day;
 5. results of preventive medical examinations of the employees;
 6. complying with sanitary requirements.
 - 5.5. Perform the career guidance of pupils (under the health aspect), taking into account their health condition.
 - 5.6. Detect pupils who need to be released from examinations and transferred to a special health group in the physical training classes.
 - 5.7. Perform educational health work with pupils, parents and the school employees.
 - 5.8. Undertake measures to prevent trauma, keeping records and making analysis of each case of injury.

- 5.9. Improve their professional knowledge and contribute to the training of health care personnel with secondary education.
- 5.10. Keep records of the material and technical basis of the health care station and contribute to its provision with equipment and medications.
- 5.11. Record the information on the pupils' state of health and submit it by 10 January of each year to the medical director of the family health centre and the centre of preventive medicine.

Duties of health care worker with secondary education (medical assistant, nurse)

6. The health care worker exercises his/her duties under the management of the school physician or family physician (if there is no school physician).
7. The health care worker with specialized secondary education must:
 - 7.1. Examine the pupils annually, jointly with the physician, in order to detect various pathologies, give health care to the patients.
 - 7.2. Do all the errands of the physician, including the filling in of health cards (anamnesis, data on the pupils' immunization, recent illnesses, anthropometry, determination of visual acuity, collection of biological assays etc.).
 - 7.3. Inform the teachers, jointly with the physician, about the results of the comprehensive medical examination of pupils, filling in the medical sheet of each class's register.
 - 7.4. Keep an account of the medical forms compliant with the orders of the Ministry of Health of the Republic of Moldova no. 214 of 8 September 1993, and no. 288 of 25 August 1992.
 - 7.5. Check the way hygiene requirements are met in compliance with the sanitary rules and standards (order of the day, training conditions, sanitary conditions, correct posture at the school desks).
 - 7.6. Check the observance of sanitary requirements at canteens, of food technology, expiry dates and storage conditions of raw materials and food, processing of the dishware and devices; take part in food quality control, examine the personnel in order to detect suppurative inflammations and enteric infections and fill in a "health" record thereupon, check whether the personnel underwent preventive medical examinations, check the use of iodinated salt, carry out monthly calculation of foodstuffs' energy value and the quantity of nutrients contained etc.
 - 7.7. Check the conditions of carrying out physical training, attend physical training classes monthly and evaluate the rate of mobility, monitor the distribution of pupils according to medical groups.
 - 7.8. Consult teachers about the correct posture of pupils at school desks and monitor the way these requirements are observed.
 - 7.9. Perform the preventive examination of pupils after vacation periods and during the school year, compliant with the Ministry of Health orders. Take part in the organization of comprehensive medical examinations of pupils.
 - 7.10. Perform the vaccination of pupils under the vaccination schedule (under the physician's supervision, after additional training accompanied by evaluation of knowledge by a special commission) and check the postvaccinal reactions, inform the parents thereafter about the vaccinations performed.
 - 7.11. Detect actively patients suffering from contagious and parasitic diseases. Perform dynamic

medical supervision after contacting the patients. Inform the preventive medicine centre, health care institution and the school director about every incident of contagious disease registered at the school. Check the conditions of training and recreation of pupils in extended-day groups.

- 7.12. Check the conditions of the pupils' education through work (socially useful production work). Take part in performance of medical examinations of pupils in work associations and camps, with filling in medical forms.
- 7.13. Compile the list of pupils and personnel, and take part in collecting assays for parasitic worm tests. Treat the patients in compliance with the physician's prescriptions.
- 7.14. Organize, check and keep records of preventive medical examinations of school personnel.
- 7.15. Engage in the health education of pupils, parents and school personnel, organize sanitary duty (jointly with the teachers).
- 7.16. Keep records of the material and technical basis of the medical station and contribute to its provision with equipment and medications (when the physician is absent).
- 7.17. Record the information about the pupils' state of health annually by 10 January jointly with the physician.

The Republic of Moldova: youth-friendly health services in 2009

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Executive summary

This case study provides an example of how a country (the Republic of Moldova) is working to introduce youth-friendly health services (YFHS) as a mechanism for promoting and protecting young people's health and development, with particular emphasis on prevention of HIV and sexually transmitted infections (STIs) and treatment and care for young people, including those who are most at risk.

The United Nations Children's Fund (UNICEF) and WHO support to the government of the Republic of Moldova has facilitated the process of establishing YFHS, which has included the development of a national YFHS concept, quality standards, monitoring tools and training and support materials for professionals. The process involved a wide range of partners, including United Nations agencies, bilateral donors, different ministries, national and municipal health workers, nongovernmental organizations (NGOs), professional associations and young people.

The purpose of this case study is to assess and document the current status of YFHS and the ability of the health system to meet the needs of adolescents, particularly most-at-risk adolescents and vulnerable groups, to highlight lessons learnt and to identify ways forward. The objectives are to:

- outline current epidemiological trends in health and health-related behaviours among Moldovan adolescents, including reproductive health issues, infectious diseases, mental health and substance use;
- assess the accessibility of health services to Moldovan adolescents and the health system context that may influence access;
- review the current framework of YFHS delivery, including policies, infrastructure and quality assurance mechanisms; and
- provide recommendations for further development of YFHS and the delivery of health care to adolescents in the Republic of Moldova.

Background

Political and economic context

The Republic of Moldova was established as an independent state in 1991 after the break-up of the Soviet Union. It is a land-locked country in south-eastern Europe covering 33 843 km². Approximately 80% of its area is rural, arable land or pasture, and the dominant industry is agriculture and food processing.

The transition period was harsh from a socioeconomical point of view; although the economy has increased by 30% and the gross domestic product (GDP) grew by 7% every year until 2008, it has still not reached the level of 1991. The global financial crisis reversed this positive trend and there is evidence that the GDP has decreased by 7.8% in the first half of 2009 and will continue to decrease in the coming years due to economic decline (UNICEF, unpublished data, 2009).

Since independence, the Republic of Moldova has faced serious economic and political challenges that have impacted on economic growth. There is an ongoing massive emigration of the workforce, particularly among the rural population. While official data suggest 309 000 people have emigrated, some unofficial data indicate that that actual number is between 600 000 and 1 million. In its *National development strategy*,

2008–2011 (1), the government of the Republic of Moldova estimates that 21.1% of the total active working population (of 15 years and older) left the country in 2006 in search of a job abroad, of which 40.3% were aged between 20 and 29 years. Only 27% of young people aged 15–24 years were employed in 2008, despite representing a higher proportion of the economically active population (UNICEF, unpublished data, 2009). Many of them choose to emigrate to other countries for work.

In addition to economic hardships, the Republic of Moldova also has a frozen conflict zone, the Transnistrian region. After the dissolution of the Soviet Union, tensions between the government and the breakaway region escalated into a military conflict which lasted for several months in 1992. The territory’s political status remains unresolved: while the law defines it as part of the Republic of Moldova, Transnistria is a de facto independent state. Neither the Republic of Moldova nor the Member States of the United Nations recognize Transnistria as a state.

The rapid changes that have characterized Moldovan society in the last decade have brought new opportunities for youth, but also risks. Issues affecting adolescents’ families, their local communities and Moldovan society compound individual health concerns. The mass emigration triggered by poor economic growth and high unemployment through the 1990s continues to strain the family unit and communities, with knock-on effects for today’s youth. But despite this decade of emigration, Moldovan culture continues to place a high priority on marriage and family, with most Moldovan youth keeping strong ties to both their family and community. Such ties need to be nurtured as they offer a means to the development of strong and healthy communities in which young people in the Republic of Moldova can grow.

Demography

Young people in the Republic of Moldova today are the first generation raised after the declaration of independence in 1991. Due to the demographic “explosion” in the 1970s and 1980s, they are the most numerous of all age groups in the population structure. As of 1 January 2008, the population aged 10–24 years constituted 26% of the total population, or 930 500 people, which is a relatively important share (2). The age category 20–25 years is the most numerous of all age groups, but the decline in the birthrate presages an increased proportion of older people in the population, and a serious reduction in the absolute number of young people in the Republic of Moldova is already being seen. The window of opportunity for interventions from which these young people would benefit is very tight (only a few years) since the demographic pyramid shows a significant reduction in youth aged 15 or less (Fig. 1).

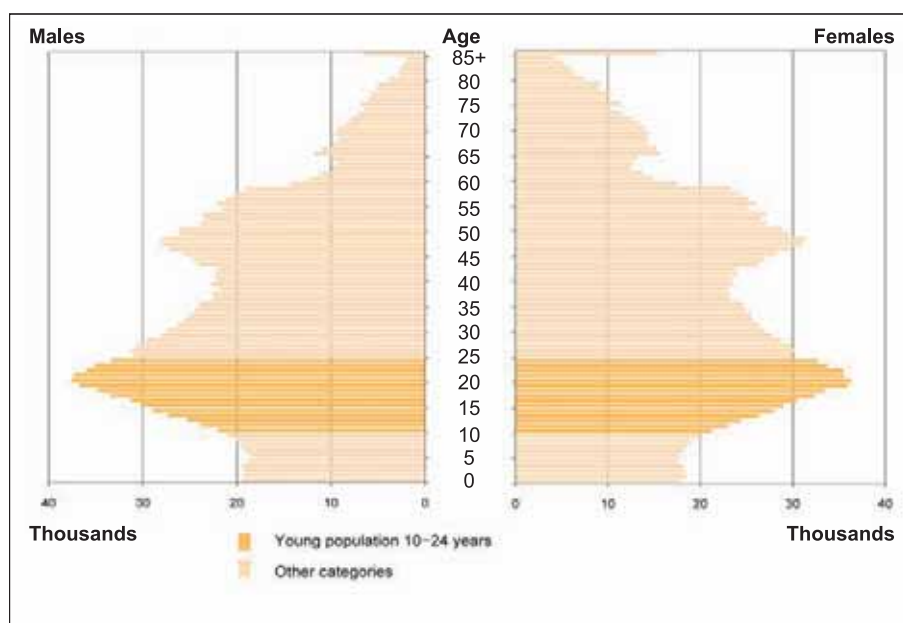


Fig. 1 Demographic pyramid in the Republic of Moldova, 2008

Source: National Bureau of Statistics of the Republic of Moldova, 2008

An overview of demographic statistics in the Republic of Moldova is presented in Table 1.

Table 1. Demographic overview, Republic of Moldova

| Indicator | Value | Year | Source |
|--|-----------|------|--|
| Total population | 3 567 500 | 2009 | National Bureau of Statistics, 2009 |
| Population growth | -1.4% | 2007 | National Bureau of Statistics, 2009 |
| Life expectancy: males/females | 65.0/72.6 | 2007 | National Bureau of Statistics, 2009 |
| Total fertility rate | 1.26 | 2008 | Central Intelligence Agency (CIA) (3) |
| Total expenditure on health per capita (US\$, 2006) | 190 | 2006 | WHO Statistical Information System (4) |
| Total expenditure on health (% of GDP) | 5.4% | 2008 | WHO Statistical Information System (4) |
| Under-5 mortality (per 1 000) | 14 | 2007 | Ministry of Health statistics, 2008 |
| Infant mortality (per 1 000 live births) | 11.3 | 2007 | Ministry of Health statistics, 2008 |
| Percentage deliveries with skilled birth Infant mortality (per 1 000 live births) | 99.1% | 2007 | Ministry of Health statistics, 2008 |
| Abortions per 100 live births | 42.3 | 2007 | Ministry of Health statistics, 2008 |
| Percentage abortions in age group 15–19 years | 8.9% | 2007 | Ministry of Health statistics, 2008 |

Several reviews and studies highlight the health issues affecting Moldovan adolescents: sexual health (STIs and HIV, unwanted pregnancies and abortions); substance use (excessive alcohol consumption, smoking, illicit drug use); road traffic accidents; and mental health and suicides. In addition to health issues, young people are affected by high levels of unemployment, lack of informal development opportunities, crime and the pressure of emigration (UNICEF, unpublished data, 2009). These issues will be addressed in more detail in the next section.

Society and youth

Education

People in the Republic of Moldova are being increasingly exposed to a wide array of educational opportunities. The most recent demographic and health survey (5) showed 65% of men and 56% of women have completed secondary schooling. Stratified data show increasing numbers of young adults completing secondary education, with 30% of men and 40% of women aged 20–24 years beginning tertiary education (5).

Family

The average age at first marriage is 23 years for women and 25 years for men (5). Sixty-nine per cent of children live in two-parent families and 20% in single-parent households, with 15% living with their mother and 5% with their father. The majority of single-parent families have one parent living and working abroad. Contrary to common belief, the number of births outside marriage is steadily increasing, from 17.3% of all births in 1997 to nearly 25% in 2006 (6). This compares with levels of 28% in Romania and 21.4% in Ukraine in 2006. The number of births to women under 20 years has continued to decrease, with 19.7% of all births recorded to mothers under 20 years in 1995 compared with 13% in 2006 (6).

Emigration

Approximately 25% of the working population of the Republic of Moldova has emigrated over the last 15 years (7). The trend is for children to be left behind by emigrating parents, with the most common

emigrating age group being 20–29 years (accounting for approximately 25% of all emigrants). This reflects the average age of marriage. Moldova has had negative population growth for the last decade, chiefly due to a low fertility rate and high rates of emigration (4).

Women

Generally, women enjoy a high degree of input into the management of household finances and accessing health care for their families. Although domestic violence is generally considered unacceptable, 27% of adolescent women will experience some form of violence in their lifetime, with 13% of adult women experiencing violence in the last 12 months (5).

Health knowledge, attitudes, behaviours and outcomes

Sexual behaviours and reproductive health

Initiation to sex in the Republic of Moldova starts at around age 16, and about a quarter (26.9%) of adolescents have their first intercourse before the age of 18 years (8).

While the proportion of young people becoming sexually active early in life is relatively small, their sexual practices are not always safe. In a 2008 survey of young people’s knowledge, attitudes and practices regarding HIV/AIDS (8), 10% of respondents had non-permanent sexual partners and 18% of those who had never married or had no long-term partner had two or more sexual partners in the past year. Ten per cent of the sample reported having had commercial sex in the past year. Just under 63% of the young people who had had sexual relations reported condom use at their first sexual contact, compared to 45.6% in 2005 (9), and 53.6% of 15–24-year-olds reported condom use at last intercourse (Fig. 2).

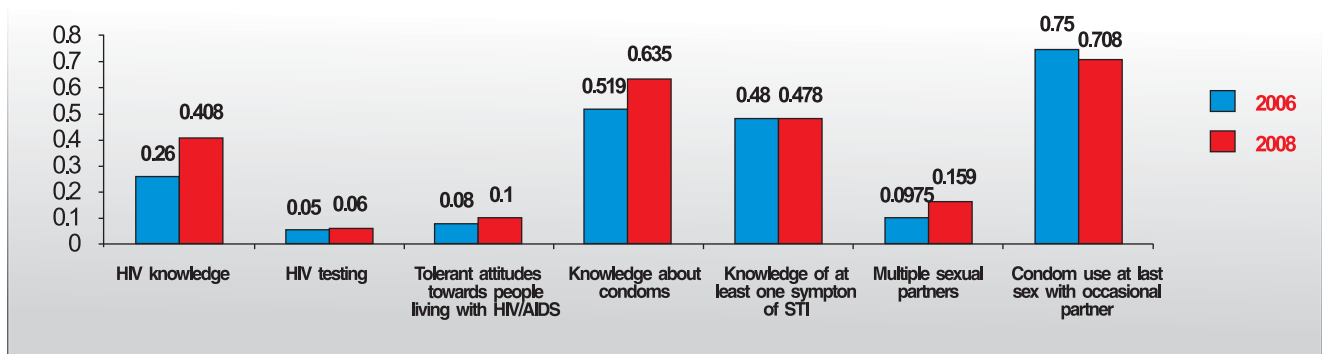


Fig. 2 Main indicators of knowledge and sexual behaviours in youth aged 15–24 years, 2006 and 2008 (8,9)

Abortions are legal in the Republic of Moldova during the first 12 weeks of pregnancy and up to 21 weeks for “outstanding medical reasons”. Currently, 35% of all pregnancies in the country end in termination. According to the demographic and health survey of 2005, 66.1% of pregnancies among young women less than 19-years-old and 63.7% in the 20–24 years group end in abortion (5).

The maternal mortality rate improved between 1997 and 2007 from 50 deaths per 100 000 live births to 15.8. A relatively high maternal mortality rate has been associated with social determinants and prenatal morbidity.

HIV/AIDS and STIs

The HIV incidence in youth aged 15–24 years increased from 13.32 in 2006 to 14.34 in 2007. There were 129 new HIV cases in this age group in 2008, accounting for 16.3% of the total number of new cases. The main mode of transmission in 2008 was sexual intercourse (72.1%), with sharing injecting equipment accountable for only 26.2% of new cases (10).

The incidence of sexually transmitted infections (STIs) in the Republic of Moldova is very high compared to other European countries. In 2006, it was 186.8 per 100 000 15–19-year-olds (202.6 in boys and 170.5 in girls), compared to 119.6 in the total population. This situates the Republic of Moldova in second place in the European Region after the Russian Federation (11). The 2008 survey of young people's knowledge, attitudes and practices regarding HIV/AIDS (8) showed that although young people had heard about STIs, less than half (47.8%) could name at least one STI symptom; this was not significantly changed from the 2006 survey (48.0%) (9).

Awareness of HIV/AIDS among Moldovan youth is high, with most (97%) being aware of the disease, although knowledge of transmission routes is still poor (5). The integrated HIV knowledge indicator has significantly increased from 26% in 2006 to 40.8% in 2008, but voluntary HIV testing has remained low at 6% and tolerant attitudes towards people living with HIV/AIDS is alarmingly low at 10% (8).

Smoking

As elsewhere, smoking among young people in the Republic of Moldova usually becomes established in adolescence. The 2005 demographic and health survey reported that as many as 51% of the male Moldovan population regularly smoked cigarettes (5), while the 2008 knowledge, attitudes and practices survey showed that 22.8% of young people aged 15–24 years were smoking and another 17.3% had smoked in the past, meaning that 40.1% of respondents had already had exposure to smoking in their lifetime (8).

Alcohol

Moldova also has high rates of alcohol consumption, with an average intake of 12 litres of pure alcohol per person per year. This figure has remained stable since 2004 (12). In 2008, 81.8% of Moldovan youth aged 15–24 years consumed alcoholic drinks, with higher proportions in boys. Binge drinking was reported by more than half of respondents, with 58.7% having six glasses of wine or more (or its equivalent in strong drinks) in single sessions (8).

Illegal drugs

While the use of milder drugs such as cannabis and “Ecstasy” is lower in the Republic of Moldova than in European Union (EU) countries, the prevalence of injecting drug use is high. The European average lifetime prevalence of cannabis use among 15–24 year olds is 30.7%, compared to 3.4% in the Republic of Moldova, and “Ecstasy” use lifetime prevalence among 15–34-year-olds in Europe is 5.6% but 1.3% in the Republic of Moldova (13). In relation to opioid drug use (usually equivalent to injecting drugs), however, while EU countries report an annual prevalence of between 0.1% and 0.6% of the population aged 15–64 years, the general population survey in the Republic of Moldova reports a 0.5% opioid lifetime prevalence in the same population group and a lifetime prevalence of 1.0% in the subset population of 15–24 years (13).

Mental health

Mental health issues among young people have received little attention at government level in the Republic of Moldova. People affected by mental illness receive no substantial support from the state or private sector (14). This is despite increased reporting of mental illness among young people aged 18 years and younger between 2005 (486 per 100 000) and 2006 (603 per 100 000). Of these, approximately 74% of the disorders were classed as nonpsychotic illnesses (15). “Mental deficiency”, or learning difficulties, is included in these figures.

Suicides

The number of suicides in the age group 0–18 years increased sharply between 2007 and 2008. Data extracted from National Mortality Database show that suicide mortality rates are higher in boys: in 2008, it was 11.7 in boys aged 15–19 years and 18.24 in boys aged 20–24 years, compared to 3.82 in girls aged 15–19 and 1.71 aged 20–24 years.

Development of the YFHS initiative in the Republic of Moldova

Health system context

Prior to the establishment of the youth-friendly health centres (YFHCs) in 2001, health services available to young people in the Republic of Moldova were based on the old Semashko model in conception and delivery. Health services planning and delivery was based on historically shaped inputs (such as the number of available providers) rather than needs, and covered large proportions of the population rather than focusing on specific target groups. Some polyclinics had adolescent health offices whose main responsibilities were providing medical check-ups for military conscripts and general preventive physical examinations for various categories of young people. In addition to the general health system, a system of health units in education facilities (schools, colleges and universities) was responsible for preventive medicine and routine check-ups of the young people enrolled in those institutions, but while this system has great potential, it still operates within the ethos of the old “disease control and screening” paradigms.

During the Soviet regime, most health-seeking behaviour was focused on hygiene and physical activity. Given the taboo surrounding sexual issues and STIs, and the fact that notification of family and partners of those seeking treatment for STI was mandatory, the system discouraged young people from seeking health care and persuaded them to seek out other informal sources for treatment that would ensure anonymity. All school-going adolescents would attend the school health service (school nurse, visiting paediatrician and paediatric gynaecologist) for health checks.

Under the general health reform, the Republic of Moldova has adopted a three-tiered health service delivery structure. Primary health care (PHC) is delivered through family physicians who can refer to secondary level for specialized care services or inpatient care. Tertiary care is usually provided at national level by reference hospitals.

The physical infrastructure for new PHC facilities is, in general, the former “polyclinic”. Transforming these clinics into “friendly”, “client-focused” and “quality-assured” facilities continues to be a major task for the Ministry of Health, involving not only refurbishing existing clinics, but also challenging long-established ways of providing medical care.

The collapse of the Soviet system and the adoption of PHC networks changed the entry points for adolescents into the Moldovan health care system. Today, adolescents can (in principle) access health care through an assigned family practice. The YFHS network developed as an adjunct to this service provides an independent entry point into the health system. It has the capacity to manage adolescent issues, including sexual health, which has been identified as the most sensitive issue and the one which prevented many young people accessing general health care services.

Establishing a YFHS network

Following the adoption of the YFHS concept by the Interagency Group on Youth-friendly Health Services in 2001, the Republic of Moldova has embarked on the road of reforming its youth-targeted health system. The first steps, taken between 2001 and 2003, were to establish pilot YFHCs while also advocating for national policy development on YFHCs, capacity building for service providers within existing services, and the development of national norms and standards for quality youth-friendly services.

Pilot centres

The first established clinics were “Juventa” in 2001 in Chisinau, the capital city (the clinic changed its name to the Methodological Centre of Reproductive Health and Medical Genetics in 2004), “Neovita” in 2002 in Chisinau, and “Junona” in 2003 in Stefan Voda, which operated with support from UNICEF. With support from the International Development Association (IDA), the World Bank and the Swiss Development Cooperation Agency, 11 new centres were opened in 2005 following an open tendering process. A more detailed consideration of the services provided in clinics is shown at Appendix 1, and Appendix 2 relates some experiences from service users and professionals.

Political endorsement

The concept of YFHS was endorsed through the most important policies in the area of youth and health, such as the *National health policy (16)*, the national youth strategy for 2009–2013 (approved by the Parliament of the Republic of Moldova on 3 March 2009), and the *National strategy on reproductive health, 2005–2015 (17)*.

National ownership

In parallel with setting up model service-delivery centres, a working group was established at Ministry of Health level to provide overall coordination of youth-friendly health services all over the country. It also had specific tasks, such as the generation of a national concept paper, the development of norms and standards, the approval of guidelines and curricula for YFHS, and the development of a strategy for the integration of YFHS into the existing network of health care facilities.

National concept

The *National concept paper on youth-friendly health services in Moldova (18)*, published at the end of 2005, is the cornerstone of the YFHS approach in the Republic of Moldova. This paper:

- defines youth-friendly services in the Republic of Moldova;
- sets working principles and components of YFHS;
- outlines the model of implementation of YFHS and its integration into the existing health system;
- sets the minimum and extended packages of YFHS and the coordination mechanism;
- defines responsibilities at national and local levels; and
- sets a monitoring and evaluation framework.

One of the most important aspects of the concept paper is the distinction it makes between services provided in a youth-friendly manner and those in the general health care system. The concept paper (and the clinics) emphasize that the services are oriented towards promoting healthy development in adolescents and preventing (and responding to) health problems if and when they arise. Interventions need to be delivered to meet the following three goals:

- the creation of a safe and supportive environment
- the provision of information to build life skills
- the provision of health and counselling services.

At the same time, the approach within the services needs to be non-judgemental, with the provision of information and counselling seen as indispensable.

The key values of YFHS adopted by centres in the Republic of Moldova are shown in Box 1, and the components of YFHS in Box 2.

Box 1. Key values of YFHS adopted by centres in the Republic of Moldova

- Full participation of young people
- Peer education and life skills-based education
- Integration with other services and sectors
- Service providers trained in youth-friendly approaches, counselling and communication
- Privacy
- Confidentiality
- Quality of care

Box 2. Components of YFHS (18)

1. Promotion of healthy lifestyle
2. Prevention of health and development problems

3. Diagnosis of specific health problems (HIV, STI, obstetric/gynaecological)
4. Treatment and health care of certain conditions
5. Rehabilitation
6. Referral
7. Free distribution of health promoting materials and use of reproductive supplies (information, education and communication (IEC), condoms, contraception, pregnancy tests, STI drugs)

Guidelines development

Guidelines for the provision of YFHS were developed and adapted for the Moldovan context in 2004. National experts were involved in this process, including doctors, psychologists, social workers, nurses and active volunteers. So far, guidance for YFHS volunteers has been adapted for the Moldovan context and several more are under development, including guidance for YFHS managers, guidance for managers on implementing YFHS quality standards, guidance for YFHS counsellors, and guidance on working with most-at-risk adolescents (MARA) and especially vulnerable adolescents (EVA).

Development of quality standards and their implementation

The development of quality standards and indicators for youth health services started in 2006, with technical assistance from UNICEF Moldova, WHO Regional Office for Europe and WHO headquarters. The final version was approved by the Ministry of Health in 2009 and has six basic standards that aim to lessen obstacles to access to health services for young people:

1. standard 1: young people know when and where to ask for health services
2. standard 2: young people have ease of access to health services they need when they need them
3. standard 3: service providers respect youth confidentiality and privacy
4. standard 4: health services mobilize the community to promote friendly health services for youth
5. standard 5: health service providers supply effective and comprehensive services according to the real needs of young people
6. standard 6: all young people have equal access to health services.

More detailed information on the components of each standard is provided at Appendix 3.

A plan of action was developed to accompany the standards to ensure they are being implemented. It is clear that an enabling environment is needed to translate aspirations captured by the standards into practice.

Provider training

All health care providers in the YFHCs were trained in adolescent health and counselling according to the WHO *Orientation programme on adolescent health for health providers (19)*.

YFHC premises

Many YFHCs have been renovated and have received equipment for facility-based services and outreach activities. They have developed pleasant and attractive environments for young people. Minimum requirements for space were established in 2006, and a YFHC should include a waiting area, counselling rooms, a medical examination room, a hotline room, training space and computer room. Most of the centres comply with these requirements.

Staffing

Most of the centres initially hired specialists such as obstetricians/gynaecologists, STI specialist, urologists, internal medicine specialists, counsellors (psychologists) and social workers. Minimum staffing requirements were set in 2008 and include the full or part time positions of: manager of the centre, receptionist, obstetrician/gynaecologist, STI specialist (dermatovenereologist), internal medicine specialist, psychologist/counsellor, social worker, nurse or midwife. An assessment in 2009 showed that all centres are understaffed, some more severely than others, hindering service capacity. Those centres that have at least one full-time employee perform better than those where everyone works on a part-time basis.

Participation of young people

Many centres have involved groups of young volunteers to take part in their activities. YFHCs have invested in capacity development of these young people and have supported the activities of several generations of volunteers. Volunteers act as peer educators but also take part in all outreach activities; some also take part in activities in the centres.

Structure of YFHS

Today there are 12 YFHCs in the Republic of Moldova. A few centres serve as models of excellence and will probably act as referral centres when youth-friendly health approaches are integrated within the primary health care network. The methodological centre in Chisinau acts as a national referral centre for some reproductive health problems (such as contraception, pregnancies and infertility) but is mainly responsible for the development of strategy, guidelines and standards and for monitoring, evaluating and reporting. Referral patterns are currently established between the YFHCs, NGOs and specialized health institutions, although these referrals are not formalized (Fig. 3).

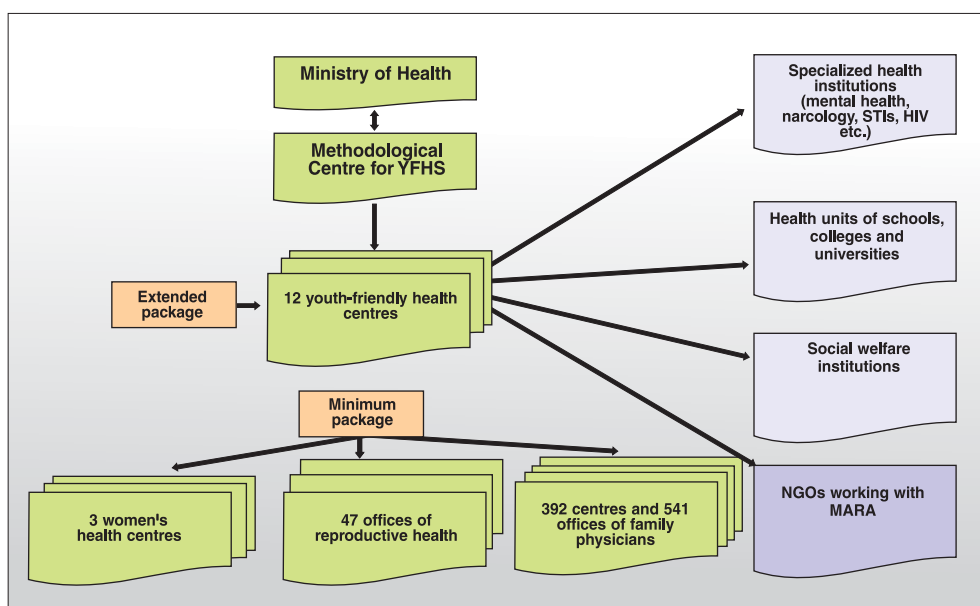


Fig. 3 Design of YFHS and inter-institutional referrals

The national concept paper (18) outlines that PHC providers (family physicians, reproductive health offices) and women's health clinics will be part of the YFHS network by providing a minimum package. This has not been implemented yet, but discussions are underway about including them soon, provided that appropriate training and resources are available to them. Minimum packages of YFHS also can be offered by specialized institutions.

Under the quality standards for YFHS, services are described as either "minimum" or "extended" packages. Both include medical consultation, counselling, and information, education and communication (IEC) activities and referrals, but to different extents. In addition, the extended package includes coordination of YFHS activities in the catchment area. The 12 YFHCs provide extended packages, while any institution or practice group interested in becoming a YFHS has to meet the requirements for a minimum package and competencies of staff (Table 2).

Table 2. YFHS minimum and extended packages

| Main areas of intervention to reduce: | Minimum package | Extended package |
|---|---|---|
| <ul style="list-style-type: none"> ● STIs and HIV incidence ● unwanted pregnancies and unsafe abortions ● use of alcohol, drugs and other substances ● psychoemotional disorders ● violence ● nutrition problems ● developmental disorders | <ul style="list-style-type: none"> ● medical consultation ● counselling ● IEC activities ● referral | <ul style="list-style-type: none"> ● medical consultation (plus testing, diagnostic and treatment) ● counselling (plus voluntary counselling and testing (VCT), for adopting safe behaviours, psychological, social/legal) ● IEC activities (plus training for service providers) ● referral ● coordination of YFHS activities |

Provided services

The YFHCs provide one of the few areas in the health care system in which multidisciplinary teams offer integrated services. Facility-based services are obstetric/gynaecological consultations and referrals, STI counselling and management, urology or andrology services for boys and young men, internal medicine specialist services, psychological counselling and social work services. Information and outreach activities are oriented towards reproductive health, mental health, personal skills and communication, violence prevention, healthy lifestyle, prevention of HIV, tuberculosis and hepatitis, healthy nutrition, and children’s rights. In addition to consultations, the centres provide some free prevention materials (leaflets, booklets, condoms, oral and emergency contraception when available, free pregnancy tests, etc). Several centres also have phone consultations (Fig.4).

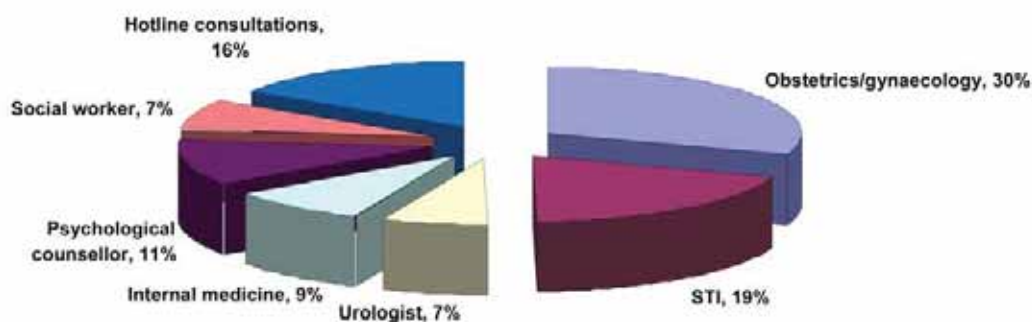


Fig. 4 Distribution of consultation services provided by YFHC network, 2008
 Source: Lesco G, Ciubotaru V, unpublished data, 2009

Obstetric/gynaecological consultations

Obstetrics/gynaecology is by far the most popular service, accounting for 36% of the total number of consultations provided in 2008 (the most frequent attendees of YFHCs in general are girls and young women). The non-judgemental, user-friendly approach, assurance of confidentiality and free access are the most important factors in increasing access to this service. The obstetrics/gynaecology services most often include contraception and pregnancy testing and diagnosis and referral to treatment for certain conditions. In addition, obstetric/gynaecology specialists counsel on issues related to sexuality and reproductive health.

STI diagnosis and management

Diagnosis and treatment of STIs is another common reason for accessing YFHCs, with STI consultations ranking second (23%) in the total number of consultations in 2008. In fact, many more young people request these services, but providers have limited capacity to provide STI counselling, diagnosis and treatment services free of charge to vulnerable and uninsured young people. The STI specialist is a dermatovenereologist, so many young people attend this specialist because of age-related skin problems.

Hotline

Telephone information and counselling has been added to the list of services in only four centres, even though it is a service in high demand (ranked third (16%) in 2008). Any staff member on duty can answer the phone and most people can call according to a specified schedule detailed in handouts given to clients during outreach activities or in the facility. For many, calling is the first step to accessing services, as there are still barriers to be overcome for clients to feel confident in service providers. In addition, the helpline saves time and money for those out of town. Telephone counselling can help solve a problem without a visit to the clinic, reducing the number of unnecessary visits and waiting times.

Counselling

Counselling is a skill that makes service providers from YFHCs different from what young people experience when attending health care providers in other settings. Health providers from YFHCs help young clients to make informed decisions and choices in dealing with their issues related to contraception, pregnancy or STI, or before referring to HIV testing. Also, many centres offer psychological counselling for various situations, such as those related to parent emigration, relationships, conflict situations with peers or at school, violence and many other life situations that cause young people stress. Behaviour change counselling is offered to adolescents at risk. Counselling accounted for 11% of the total services provided in 2008. Starting in 2009, voluntary counselling and testing (VCT) for HIV and hepatitis will be added to the list of counselling services.

General health

Although just four centres have internal medicine specialists on their staff, this is usually a popular service (ranked fifth with 9% in 2008), especially for vulnerable adolescents and young people who cannot access the public health system because of lack of health insurance and the stigmatizing attitudes they confront. In YFHCs, they have free access to diagnosis of general health problems not related to sexuality or infections.

Urologist

Young men usually visit clinics only when referred or when brought by their female partners, and very few visit on their own initiative. Of the total number of clinic visitors in 2008, 34% were boys. They less often admit to having issues that need specialist consultation and usually access YFHCs for sexuality counselling related to sexual activity and for STIs. Only three clinics offer urologist or andrologist services, but they accounted for 7% of the total number of consultations provided in 2008, suggesting that this service would perhaps attract more male clients if it was scaled-up.

Social services and referral

The range of social services varies by site and by the capacity of social workers to refer to other existing services or provide some financial aid from the centre. Social workers help adolescents and young people by providing counselling on various difficult life situations to which they cannot find solutions and by providing or referring to free services that the adolescents are not aware of, such as temporary placement in the case of problems with housing, referral to employment agencies and referral to social services if they are entitled to social benefits. Five clinics provided social services and in 2008 it accounted for 7% of the total service provided.

Outreach activities

Outreach activities include promotion of healthy lifestyles and peer-to-peer education in schools and universities, but only a couple of YFHCs also have specific outreach activities for at-risk young populations such as street children and homeless young people, social orphans, adolescents from socially vulnerable families, victims of violence and trafficking, injecting drug users (IDUs), commercial sex workers and those who are lesbian, gay, bisexual or transgender (LGBT). The number of young people who receive information and support through outreach activities is usually higher than those who access facilities.

Evolution of YFHS capacity

The number of beneficiaries of YFHS increased from roughly 15 000 in 2004 to around 70 000 in 2007. From 2008, the services of these clinics have been reimbursed by the National Health Insurance Fund (NHIF), meaning the first half of the year was marked by erratic activity of all the centres. Around 54 000 young people accessed services in 2008, of which 19 000 (35%) accessed medical, psychological and social services, 32 000 (59%) were beneficiaries of information activities and approximately 4000 (6%) accessed telephone hotlines. The proportion of first-time visitors was 54%, and 66% of the clients were girls (Fig. 5).

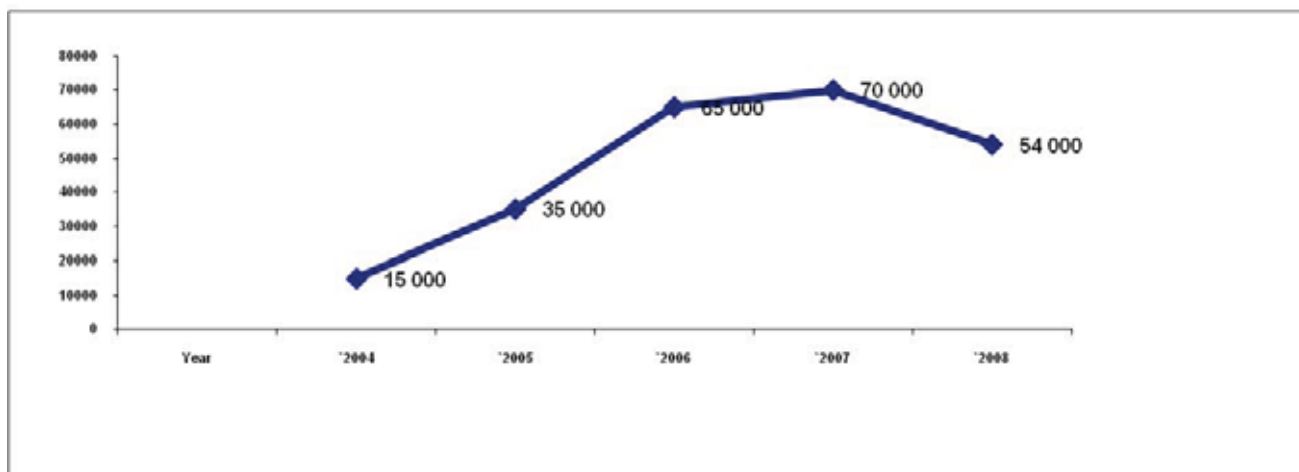


Fig. 5 Number of clients of YFHCs, 2005–2008

Key success factors

Quality and dedication of staff

The most important key to success is appointing the right, dedicated people to do the job. The YFHCs in the Republic of Moldova have had difficult times of transition and work in underfunded conditions, so commitment and enthusiasm despite low salaries and uncertainty is what keeps the YFHS going and attracts so many young people.

Difference in approach

The staff are non-judgemental and friendly and are open to discuss issues that are usually considered taboo; this increases the willingness of adolescents to come again and again to the centres. Many adolescents

state that they are very comfortable talking to YFHC staff and feel they are treated without formality or patronizing attitudes, which constitutes a significant difference to their prior experiences in health care.

Free services

For many adolescents and young people, free or low-cost services (especially for those without health insurance) are of paramount importance to their capacity to benefit from services. Many are poor or have no independent sources of income, so this is a critical consideration in the client's decision to access the services they need or not.

Participation of young people

Participation of young people as volunteers brings additional energy and variety to the activities of the centres. It also gives an opportunity to enhance the centres' outreach capacity by enabling "wins" for key stakeholders: the volunteers gain work and life experience and develop their personal skills, and the populations they interact with receive new information about healthy lifestyles and increase their awareness about services they can access.

Close collaboration with other NGOs

The review of the centres' activity has shown that YFHCs with close connections with other NGOs in their cities tend to be more successful in attracting new people and satisfying all the needs of their clients. Cross-referrals between NGOs and YFHCs have a synergic effect on the services of all organizations in that particular location.

Government support and political will

The Ministry of Health has embraced the concept of YFHS as a key effective strategy in work with adolescents and young people and has included the YFHS approach in all relevant policies at ministerial and government levels. This was very important in lobbying for the takeover of financing of YFHCs by the NHIF.

Donor collaboration

The establishment of the existing clinics was made possible by support from many international donor agencies: UNICEF, the World Bank, IDA, the Swiss Agency for Development and Cooperation, WHO and UNFPA. Their close collaboration made possible the streamlining of funds and cost-sharing of various components of developing a new system in working with adolescents, but also lobbying at political level for continued sustainability.

Moving beyond piloting to a national network of YFHS

While the existing YFHCs clearly have made a difference in providing new types of services and attracting significant numbers of young people to access their services and outreach efforts, their nationwide coverage remains modest. The first challenge was to ensure sustainability of youth-friendly services after donor funding ended. The second challenge now is to expand the service nationwide in the most cost-effective manner, maintaining youth-friendly working principles and reaching the most vulnerable young people.

Sustainability

Developing a YFHS is complex, especially if YFHCs require incorporation into the three-tier health delivery model in the Republic of Moldova. Issues relating to physical location, infrastructure, personnel, financing (salaries, drugs, supplies, maintenance) are difficult to resolve, especially in resource-poor settings. It is unfair to health care workers and young people to raise the expectations of such services beyond what the health care system can reasonably hope to provide on an ongoing basis.

The first step towards sustainability was the transfer of financing of the 12 YFHCs from donor funding to the NHIF. This is considered one of the most important achievements in ensuring sustainability of the new services, yet much remains to be done to improve the financing mechanism.

Current Ministry of Health priorities are expansion of YFHS by establishing new centres and incorporating them into existing public health institutions at rayon [county] level and by developing YFHS through other entry points, such as reproductive health offices, PHC providers and health units in education institutions. Development of certification and accreditation requirements is necessary to enable this, as is a unified monitoring and evaluation system.

Quality of care

To receive adequate funding and to retain their status, YFHCs need to demonstrate good quality of services and that the services they offer are better than those provided in the general health system. Compliance with minimum standards of quality is required to ensure clients' access to friendly and quality services.

Prior to enacting the new standards, a group of six national experts conducted a baseline assessment of the compliance of existing YFHCs and assessed women's health centres and reproductive health offices against the new quality standards. A total of 98 clients of the facilities (12 YFHCs, 2 women's health centres (of the existing 3) and 6 reproductive health offices (2 per geographic region, out of a total of 47)), 179 young people from communities in the catchment areas, 74 service providers and 20 centre managers were interviewed (Lesco G, Ciubotaru V, unpublished data, 2009).

The results for YFHCs (Fig. 6) showed that the highest levels of compliance were in relation to:

- standard 1: young people know when and where to ask for health services (70.2%)
- standard 3: services providers respect youth confidentiality and intimacy (67.8%)
- standard 2: young people have ease of access to health services they need when they need them (67.0%).

The lowest compliance was for standard 5: health service providers supply effective and comprehensive services according to the real needs of young people (41.1%).

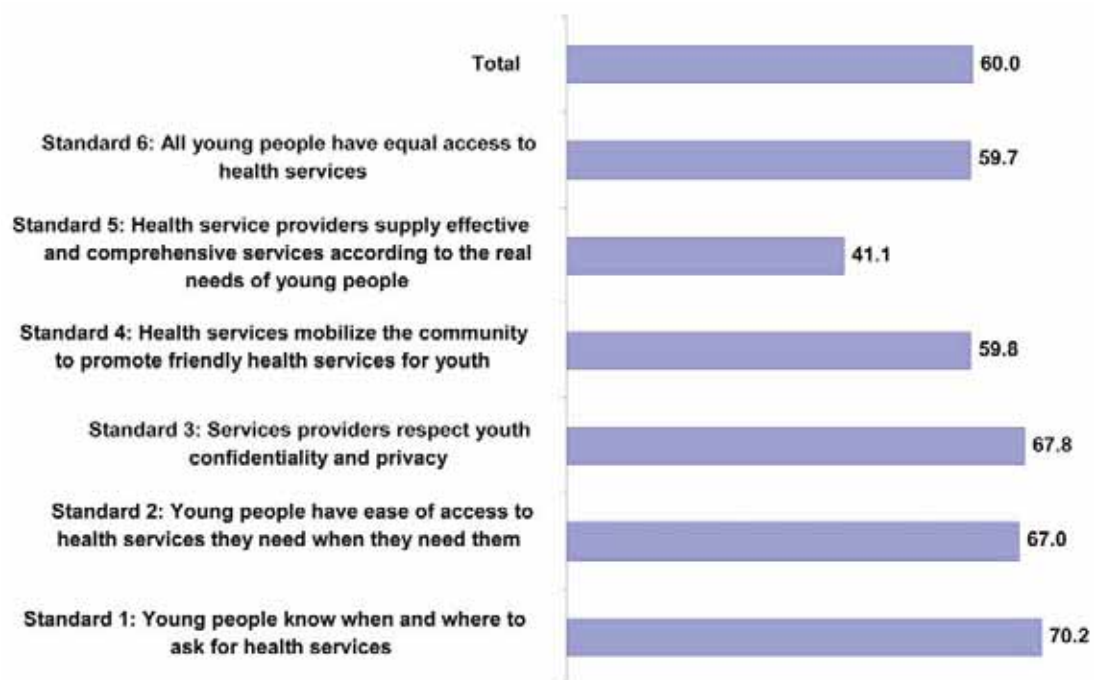


Fig. 6 YFHCs' compliance with quality standards (%)

These findings correspond with the main effort in this first phase of establishment of YFHCs: to establish confidential services, provide free or low-cost services in a friendly manner, and promote the services in communities. The effectiveness of the service, measured mainly against evidence-based guidelines,

protocols and job aids, was not explicitly tackled in the initial efforts. The widespread use of evidence-based decision-support tools is an as-yet unresolved issue for the entire health system in the Republic of Moldova, but it is also true that what is available did not penetrate practice in YFHS provision. More efforts need to be put into mapping existing decision-support tools and adapting them to the needs of clients and providers of YFHS.

Because of financing issues, this first phase could not ensure adequate staffing, equipment and supplies to allow a comprehensive service and equal access for all young people. Achieving these standards will be the next objective after the financing mechanism is properly established.

The results of quality standards assessment for the other institutions showed that the two women's health centres met the YFHS standards for extended packages in almost the same proportion as YFHCs (59.9% versus 60%), while reproductive health offices still needed support to provide even the minimum package.

Monitoring and evaluation

As YFHCs were developing, monitoring and evaluation tended to focus on counting the number of beneficiaries, but there was no unified framework for this, with each centre reporting differently. There is a need for a unified monitoring and evaluation framework that focuses not only on process indicators, but also on output and outcome indicators and quality indicators. This shift in focus would enable the YFHCs to better document their activities and would support their arguments for more investment in youth-friendly services. The quality standards and their criteria are the basis for future monitoring and evaluation activities.

The Ministry of Health sees monitoring and evaluation as essential for identifying best practices and improving the quality of care and service provision. "Best practice" treatment is also supported by the national reproductive health strategy, the HIV/AIDS programme and the development of the family practice PHC system. The National Centre for Management in Health, which is responsible for health monitoring and evaluation in the country, has started the process of developing a unified monitoring and evaluation framework that will include minimum indicators and standardized forms and data-collection procedures based on the quality standards and their criteria and with which all YFHCs will comply.

Lessons learnt and future plans

The government of the Republic of Moldova has designated the development of YFHS as a priority in addressing the needs of young people. It gave impetus to the development and implementation of an initiative that is proving successful in many respects: making services available at appropriate times and being increasingly used; having the workforce trained in new areas relevant to adolescent health and development; making provision for financial sustainability; making progress in setting quality of care standards; and developing a system for monitoring and evaluation. However, evaluation of the experience shows that much more needs to be done to overcome constraints.

Constraints

Reaching the most vulnerable

YFHCs have been successful in providing services for increasing numbers of young people, but have not been as successful in outreaching to the most vulnerable groups of adolescents, who tend to be those who do not actively seek services. The centres lack appropriate vulnerability assessment tools and have no monitoring framework to observe trends in the number of outreached vulnerable people.

Limited funding of the YFHS

As was mentioned above, although YFHS are given a high political priority, the actual funding for YFHCs provided by NHIF covers only about 25–40% of the budgets previous to year 2008. The funding provided is limited to reimbursement of facility-based services and does not cover prevention and outreach activities (including transportation costs) or staff capacity-building needs. In addition, there are no funds allocated for the expansion of YFHS to other geographic areas and for the capacity building and inclusion of PHC and reproductive health offices in the YFHS system.

Financing mechanisms

The financing mechanisms established by NHIF are not fully developed. As a result, many confusing situations arise. For example, it was considered easiest to fund YFHS based on capitation, but also to consider YFHCs as specialized services. In addition, although the global budget is earmarked for YFHCs, two YFHCs do not receive full funding because the managers of hospitals decided to reallocate some money for other purposes.

Compliance with quality standards

This has shown that major noncompliance arises from the lack of appropriate staffing, equipment and supplies and inadequate access at facility level to authoritative guidelines and evidence-based protocols; some of these issues can be resolved with adequate funding, while others call for improvement in current work processes.

YFHS structure and referral system

Given that YFHS are still under development, many structures have not yet been included in the YFHS system, particularly primary health providers, the school health system and social services, and many referral networks still need to be established or strengthened (*more detail on this is provided below*).

Youth participation

Although youth participation is ensured at facility level, a framework to ensure continuous youth participation in the development, implementation, monitoring and evaluation of services and the development of relevant policies has not yet been established. Tools to ensure meaningful involvement of vulnerable groups of adolescents also need to be developed.

Future plans

Meeting the needs of most-at-risk adolescents

The greatest challenge currently affecting YFHS in the Republic of Moldova is developing a system that is responsive to the needs of MARA. This includes adolescents falling within the traditional MARA framework and other at-risk youth, such as sex-trafficked victims.

The overwhelming challenge painted by YFHC staff and NGOs is that of meeting the needs of adolescents within the constraints of the current resource-poor Moldovan health system. Health and social service providers lack the knowledge and tools to enable them to identify vulnerable children and adolescents. MARA and EVA require coordinated and integrated services because they do not usually demonstrate health-seeking behaviours. Staff have limited competencies in conducting complex needs assessments and referring them to other specialized services when needed. Outreach work is still underdeveloped, so the most vulnerable children and adolescents remain undetected and not in contact with services.

However, despite significant obstacles, there are health facilities and personnel interested in providing health care to at-risk adolescents. Often in collaboration with international NGOs and various donors, YFHCs have been able to develop services addressing the unique needs of commercial sex workers, IDUs, adolescent males having sex with males, street children and orphans, adolescents living with HIV, victims of gender-based violence and victims of sex trafficking (see Box 3).

Box 3. YFHC Costesti working with victims of human trafficking

A large component of the work undertaken by the Costesti YFHC is treating human trafficking victims, including those from within the Roma community.

Staff suggested that as many Roma operate outside the normal institutions that govern Moldovan society and live in impoverished conditions, they are easy targets for sex-trafficking networks.

Costesti YFHS is closely connected with the NGO Compassion, which is devoted to improving living conditions for children, adolescents and women.

Many YFHCs work in close collaboration with other NGOs that provide services to these groups and provide cross-referrals to each other. Usually NGOs refer for specialist services to clinics and clinics refer to NGOs for information or support services. This is probably one of the most successful coordination and streamlining strategies in conditions when there is inadequate funding. Yet, with the transition to the NHIF, no funding is earmarked for information and outreach activities; this will primarily affect outreach to vulnerable young people.

Health services do not perform vulnerability assessments on adolescents, which would contribute to early identification of potential risk behaviours among adolescents and consequent referral to appropriate services. A unified approach of standard assessment of vulnerability and risk for any young person accessing any health care provider should be institutionalized in the near future.

The position of YFHS within the health system and beyond

As was mentioned above, the components of the YFHS and referrals have been outlined in the national concept paper (18), but roles of YFHCs and primary health care partners that are willing to provide YFHS still need to be clarified.

There is also a need to review the overall coordination of YFHS and the division of responsibilities and authority of each agency involved. In addition, it is necessary to continue working on developing networks of youth-friendly service providers in both health care and social welfare systems, to which any of the providers could easily refer their young clients.

Referral system

One key area requiring clarification is the role YFHCs will play in the three-tier referral system. Currently, the 12 YFHCs act as PHC entry points for adolescents within the YFHS catchment area, yet they provide specialized services. They cannot cover all the needs of young people in the Republic of Moldova. Ideally, each rayon should have one YFHC to which a network of primary providers would refer, but expanding the YFHS network to all catchment areas in the country would not currently be sustainable. Perhaps a second round, or expanding YFHCs to areas without centres in proxy regions, could be considered by international donors.

The suggested alternative is for YFHS to act as secondary-level referral centres to which family practices could refer adolescents when they are unable (or unwilling) to manage adolescent-specific caseloads. The adoption of such a referral system would require all family physicians to undergo training in adolescent health and development issues.

In the long term, making primary care youth friendly is seen as the most sustainable way of meeting the Ministry of Health YFHS standards and of ensuring adequate accessibility to, and coverage by, YFHS. A youth-friendly family practice would conform to the overall health system strategy in the Republic of Moldova, and all adolescents would stand to gain from the additional training and support family practices would receive to meet YFHS targets. Other possible entry points could be reproductive health offices and health units of schools, and providers in these facilities should also receive training in the provision of youth-friendly services, basic counselling skills and vulnerability assessments.

Governance

Further clarification is needed on the role of national-level institutions in providing methodological support, technical resources, advice and tertiary referrals related to adolescent health issues. The National Methodological Centre for Reproductive Health is responsible for reproductive health issues such as contraception, pregnancies and abortions and sexual dysfunction. Neovita YFHC also provides health activities beyond Chisinau. Both referral centres currently play important roles in adolescent health in the Republic of Moldova, but some other specific services need to be included in the wider referral network, such as the national STI clinic, the national AIDS centre, dermatovenereological dispensaries and social welfare institutions.

School health service

Currently, the school health service (SHS) is under structural reform, with the Ministry of Health and Ministry of Education having begun the process of reviewing the scope and content of existing SHS and integrating them into the health system reforms and PHC network. The revision of the role of school medical assistants and shifting the emphasis from medical care to health promotion are ongoing.

SHS should be part of the overall efforts to make health services youth friendly, and they clearly have a role to play in providing the minimum package of YFHS. It is important at this stage to plan and develop appropriate referral systems between YFHCs and schools, and to provide a budget to support a YFHS capacity-building plan for school nurses that will include training in health promotion and youth-friendly approaches, developing job support materials and a monitoring and evaluation framework, and adapting quality standards for this setting.

Links with other sectors

Interactions and referrals between the health and social protection system have been overlooked for too long. The social protection system is undergoing reforms and has adopted a new model of providing social services based on income and vulnerability assessments. Social protection agencies currently refer their clients to some YFHCs, with fewer referrals being made to social services. Referral systems between YFHS and social services also need to be formalized through interagency agreements. Improved adolescent content in health professionals' training programmes in the Republic of Moldova should be complemented by similar strengthening of the adolescent content of psychology and social services curricula.

Financing

Given the economic and political crisis the Republic of Moldova is facing, the expansion of youth-friendly services will need to be underpinned by significant political negotiations, with the most cost-effective strategies for programme expansion being adopted.

The Republic of Moldova's health system operates on tight budgets with constant resource shortages. Small salaries and ever-expanding responsibilities are the main reasons for staff shortages in the health system, including YFHCs. Many YFHCs, reproductive health offices and maternal and child health facilities have been supported by external funding and have consequently been able to create higher-quality premises and better supplies than health services that currently operate within government budgets. However, there are still limitations in YFHCs' physical locations, infrastructure, staffing and basic training provision.

Steps have been taken to ensure YFHCs' financial sustainability. The transition from donor funding to state funding was not an easy one. After intensive negotiations in early 2008, the services provided by YFHCs were included on the list of services covered through the NHIF, based on the capitation principle. However, the current budget constitutes only about a quarter of the budgets YFHCs had previously. Without assured long-term financial sustainability, any investment in improving the quality of care and expanding coverage seems futile.

According to a budgetary analysis of health sector policies (Centrul de Instruire si Consultanta Organizationala (CICO) [Centre for Education and Organizational Consultancy], unpublished data, 2009),

while children and student youth account for 40.3% of insured people, they use only 13.3% of health services. This is the basic principle of social solidarity that is the cornerstone of mandatory health insurance, but the underutilization of treatment services by young people should be used in advocating to the NHIF to reallocate some of the saved resources to cost-effective preventive services for youth; this would not only delay the onset of diseases in this generation in later life, but would also result in significant cost savings for the country.

The option of covering the fiscal needs of YFHCs to provide a minimum level of services by basing estimates on historic budgets (prior to 2007) should be considered. This would allow services to be maintained at about the same level. To develop a new financial mechanism for reimbursement of YFHS, a costing exercise should be conducted. YFHS are different from traditional services provided by the health system in that they include many preventive activities for which reimbursement mechanisms do not yet exist. The new financial mechanism should also take into account the need to allocate funds to support capacity-building for YFHC staff in new areas identified as priorities: applying the quality standards, working with vulnerable populations, and meeting ongoing education needs.

Young people's voices on the services they need

Based on the preliminary analysis of YFHCs in meeting the quality standards, it appears that YFHS do not cover all the needs of adolescents and young people. A needs assessment should be conducted to enable the package of services to be adjusted to the current list of needs of young people. In addition to the services provided by YFHCs, those provided by reproductive health offices and primary health care should also be assessed, as some of these institutions have begun to provide YFHS and many more will want to do so in future.

Certification and accreditation standards

Accreditation standards for health facilities have been established and are enforced by the Ministry of Health quality assurance department, in conjunction with the NHIF. The quality standards in youth friendliness outline targets for YFHCs, but offer no practical stimulation or incentives to health workers to reach the published targets. Decisions on the structure of YFHS still need to be taken at government level, but it is suggested that the primary level of providers willing to take on YFHS will need to be certified. Most likely, existing standards will need to be adjusted to the minimum package.

Legal and policy framework regarding confidentiality and legal age of consent

Issues of privacy, confidentiality, informed consent, parental consent, age-related health competency (the evolving capacity of the child) and the enforcement of privacy laws would ideally be included in a strategic framework of youth health. Health provider trust is vital in adolescent health, and these issues need to be supported by normative frameworks and changes in the law.

Currently, a group of national professionals and policy-makers is conducting an analysis of laws, policies and regulations in the area of sexual and reproductive health in the Republic of Moldova to assess their coherence with human rights instruments ratified by the country. It is expected that the results of the assessment will identify gaps in the current framework and also barriers, including barriers to adolescents accessing sexual and reproductive health services.

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References

1. *National development strategy, 2008–2011*. Chisinau, Ministry of Economy and Trade, 2007.
2. *Women and men in the Republic of Moldova*. Chisinau, National Bureau of Statistics of the Republic of Moldova, 2008: 82.
3. The world factbook: Moldova [online database]. Washington, DC, Central Intelligence Agency, 2009 (<https://www.cia.gov/library/publications/the-world-factbook/geos/md.html>, accessed 21 December 2009).
4. WHO statistical information system [online database]. Geneva, World Health Organization, 2008 (<http://www.who.int/countries/mda/en/>, accessed 21 December 2009).
5. *Moldova demographic and health survey 2005*. Chisinau, National Centre of Public Health and Management, 2006 (<http://www.measuredhs.com>, accessed 10 May 2009).
6. *Children of Moldova*. Chisinau, National Bureau of Statistics of the Republic of Moldova/UNICEF, 2008.
7. Scanlan S. *Report on trafficking from Moldova*. Geneva, World Health Organization, 2002.
8. Scutelnicuic O, Condrat I, Gutu L. *Youth's knowledge, attitudes and practices regarding HIV/AIDS 2008*. Chisinau, MultiArt, 2008.
9. Scutelnicuic O, Condrat I, Gutu L. *Youth's knowledge, attitudes and practices regarding HIV/AIDS 2006*. Chisinau, MultiArt, 2006.
10. HIV and AIDS statistics in the Republic of Moldova [online database]. Chisinau, UNAIDS Moldova, 2007 (<http://www.aids.md/monitoring-evaluation/statistics/hiv-incidence-15-24-age/>, accessed 15 July 2009).
11. Data on children in Central and Eastern Europe and the Commonwealth of Independent States. The TransMONEE Database 2008 [online database]. Florence, UNICEF Innocenti Research Centre, 2008 (<http://www.unicef-irc.org/databases/transmonee/>, accessed 15 July 2009).
12. *WHO global status report on alcohol 2004*. Geneva, World Health Organization Department of Mental Health and Substance Abuse, 2004 (http://www.who.int/substance_abuse/publications/global_status_report_2004_overview.pdf, accessed 26 October 2009).
13. *Annual report: the state of the drugs problem in Europe 2008*. Lisbon, European Monitoring Centre for Drugs and Drug Addiction, 2008 (<http://www.emcdda.europa.eu/publications/annual-report/2008>, accessed 23 December 2009).
14. *Support to mental health reform: Moldova*. Chisinau, Swiss Agency for Development and Cooperation, 2008 (http://www.sdc.md/en/Home/Programmes/Public_Health/Mental_Health, accessed 17 August 2009).
15. Calmic V et al. Republic of Moldova: adolescent mental well-being – current situation and future trends. In: *Social cohesion for mental well-being among adolescents*. Copenhagen, WHO Regional Office for Europe, 2008 (<http://www.euro.who.int/Document/E91921.pdf>, accessed 23 December 2009).
16. *National health policy*. Chisinau, Ministry of Health, 2008.
17. *Government decision no. 913 from 26.08.2005. National strategy on reproductive health, 2005–2015*. Chisinau, Government of the Republic of Moldova, 2005 (http://www.ms.md/_files/1056-Strategia%2520Nationala%2520a%2520sanatatii%2520reproducerii.pdf, accessed 31 October 2009).
18. *National concept paper on youth-friendly health services in Moldova*. Chisinau, Ministry of Health, 2005.
19. *Orientation programme on adolescent health for health providers*. Geneva, World Health Organization/Commonwealth Medical Association Trust/UNICEF, 2006 (http://www.who.int/child_adolescent_health/documents/9241591269/en/index.html, accessed 28 December 2009).

Appendix 1. YFHCs in Chisinau and Balti

Neovita, Chisinau YFHC

The Centre Neovita was created in 2002 and acts as the YFHC for the young people of Chisinau, including vulnerable adolescents (people living with HIV/AIDS, LGBT, commercial sex workers, those with no parental supervision and those from socially vulnerable families). The centre has been designated as a centre of excellence and resource centre and was ranked highest in the recent assessment of compliance with quality standards, scoring 69.7% (the average was 60%). Around 7000 to 9000 young people access services there annually.

Centre Neovita's activities consist of facility-based services, information and outreach activities and coordination activity for the network. Facility-based services are oriented to adolescent-specific health problems such as acne and sexual health issues, and reproductive and mental health disorders. Some consultations can be provided by telephone. Annually, the centre offers some 5000 consultations.

The manager of the centre believes that case management, provided by their social worker, provides a very successful model for working with vulnerable adolescents. She describes a recent situation in which the social worker was instrumental in enabling an orphaned, pregnant 14-year-old girl with developmental disability who was referred to the centre to access all the services she needed, facilitating an ordered and timely response to her complicated situation.

Neovita currently has an active core of 25 volunteers and has developed five generations of volunteers over the years it has been active. The volunteers mainly provide peer-to-peer information activities in schools and residential institutions and take part in information outreach campaigns on the street and in discotheques, university dormitories and residential schools. They also have interest clubs in communication skills, personal development and other issues.

Neovita staff provide seminars for parents of teenagers (including foster parents of children who have been in institutions), prenatal classes for couples and courses on youth-friendly approaches and adolescent health for health professionals in their catchment area.

Neovita is a centre of excellence, so its staff are actively involved in the capacity-building efforts of YFHS in the country. This includes involvement in the development of training curricula, guidelines and information materials, participation in the development of national policies in the area of YFHS, and conducting surveys and needs assessments related to young people. It is also a resource centre on YFHS not only for all institutions in the catchment area, but also for the whole network of YFHCs. Staff from the centre have also consulted nationally and internationally in the Commonwealth of Independent States region on YFHS.

ATIS Centre, YFHC Balti

The centre's opening hours are Monday–Friday, 09:00–17:00, with afternoons being the peak time. Staffing includes a centre manager, obstetrician/gynaecologist, STI specialist, counsellor, social worker and a nurse. Young volunteers (educators and counsellors) support the technical range of services on offer. When available, free condoms, intrauterine devices and pregnancy tests are supplied through the onsite pharmacy. Balti has a close relationship with the adjacent maternal and child health centre and can access contraception and other supplies when in stock.

On average, the centre provides 2500 consultations split between obstetrics/gynaecology, STIs, internal medicine, social work and counselling services; information, education and communication (IEC) activities are offered to almost 4500 young people. The centre had roughly 500 new clients in 2008, with phone consultations adding some 600 clients per year.

Most clients are aged 15 years and over. Around 40% are vulnerable (homeless, street children, orphans or adolescents without parental supervision) and some at-risk groups are represented (injecting drug users, commercial sex workers and men having sex with men (MSM)). Many adolescents from families affected by HIV are active in participating in the centre's activities in various ways.

Staff state that for many clients, affordability of health care is still a major issue influencing their ability to access health services regularly, so providing free services, especially for those who do not have health insurance, is very important for the centre.

Many young people access the services of the social worker. With funds from Médecins du Monde (MDM) [Doctors of the World], the social worker provides free medicines for uninsured adolescents and a wide range of other services, including prevention of abandonment of children after delivery by referring women in difficult life situations to temporary placement facilities and referring street and homeless children to a centre for families and children in crisis situations.

Balti YFHS has a regular clientele who wished to share their experiences with us. Vitaly and Igor regularly visit Balti. They feel welcomed there, despite having a stigmatizing medical condition and initially arriving without an appointment. Other users reported that Balti YFHS was one of the few places that HIV-positive clients could come without feeling the effects of discrimination.

ATIS Centre has a very active outreach programme on promoting healthy lifestyles. In collaboration with the city's municipal youth and sports department, the centre runs a mainstream outreach programme for schools by providing seminars for specific age groups and for their parents. The centre's staff have established contacts with all schools and universities and schedule seminars well in advance for groups of schoolchildren and students or invite students to the centre, where they have a video library with educational films. Specific outreach programmes distribute IEC materials and condoms to young MSM and commercial sex workers and target street children.

Centre ATIS ranked second in the assessment of meeting quality standards with 66.7%.

Appendix 2. Cases of Elena, Mihai, their friends and physicians

Elena is aged 19. She graduated from high school in July and is thinking about completing her diploma and going to university. She always thought that she'd enjoy teaching, but now isn't sure if the extra study is worth it. It's expensive to live as a student and her small family can barely afford food and rent on her mother's secretarial wage. The small remittances her father sends back from Rome are only just enough to keep everything together.

Before last week, she didn't really see any other option, but while shopping with her best friend **Nadia** in Chisinau, they met a man who talked about work opportunities in Europe. He said he could introduce them to his cousin who provides Romanian documentation for Moldovans wanting to work in Italy and Germany. Elena could imagine all the fun she and Nadia could have working as waitresses and partying in Italy. Maybe she could even see her father again?

A few weeks later, Nadia and Elena talk about emigrating. Elena is keen, but Nadia isn't so sure. She's now a bit suspicious about the man they met on the street. The previous week, she had been to the Chisinau health services and had seen **Dr NN**. Nadia and her boyfriend Andrei had been talking about having sex and she wanted to talk to Dr NN about contraception. She was a little bit uncomfortable about going at first, but her high school had mentioned that the Chisinau health services had female doctors who enjoyed seeing young people, free of charge, and she thought she'd give it a try.

Actually, Nadia was really impressed with Dr NN. She was straightforward and didn't make Nadia feel ashamed for thinking about having sex before marrying Andrei. They were able to talk about all sorts of

stuff – condoms, HIV and STIs, the oral contraceptive pill and abortions as a last resort. Nadia had heard most of it before, but Dr NN really seemed to care about Nadia. She was interested in what was going on in Nadia's life and asked about her family, Andrei's health and her plans for the future.

Nadia was surprised how quickly she opened up. She even mentioned the stress her family had been under since her father started drinking after losing his job. But when she mentioned the possibility of emigrating to Europe, Dr NN's attitude changed immediately. She became very serious, talking about drug circles, sex trafficking and prostitution. She gave Nadia some information pamphlets and said she should be very careful about being lured into something that took her away from a promising life in the Republic of Moldova.

Nadia had never thought of her life as promising. She lived in a small village outside the capital. Her father had lost his job 10 months ago and was now drinking almost every night. He was never violent, but it still took a toll on the family. But she is about to begin her adult life. She'll marry Andrei in September, move out of the family home and perhaps even begin a family of her own. She might even be able to go to trade school to get her diploma. Dr NN had also suggested she attend some group counselling sessions for young adults with "family problems" and she's considering taking her up on the offer.

Nadia decides to show Elena the information Dr NN gave her about sex trafficking rings in eastern Europe. Elena initially didn't want to hear about it. Surely it's only the unlucky ones who end up with their passports stolen and paying back their debt? But then a newspaper does an exposé on "Kristine", a 21-year-old woman who left Ukraine for a marriage in the United States and found herself waiting bars in a strip club. Elena begins to reconsider her options. Perhaps life in the Republic of Moldova isn't so bad after all. The government has just announced it will give student scholarships to the "brightest" and "most deserving" to attend university. She could study part-time and work in the supermarket part-time for some extra cash.

Mihai is aged 16. Life has been hard for him. His mother left for France when he was five and his father lost his job four years ago. It was then things began to fall apart. He found himself hanging out with boys much older than him. Occasional absenteeism from school quickly became permanent. Within six months, his relationship with his father had disintegrated and he found himself squatting on people's couches. Now he scrapes together a living working a few labouring jobs and occasionally begging for spare change at the train station.

One night, while Mihai is hanging out in Chisinau train station, he is approached by someone offering free health checks at the local clinic. It's been a long time since Mihai had seen a doctor – what could they do anyway? It's not like they could get him a job. But Mihai is somehow encouraged by the social worker and the next day decides to drop in to the clinic – no appointment necessary, or so the guy said.

Mihai is surprised when he gets to the clinic. The place is really welcoming. No one questions his dirty shirt or looks at his shoes. He is offered a warm drink while he's waiting to see **Dr DM**. Mihai is surprised how friendly everyone is, including Dr DM. He doesn't ask too many questions and gets on with the business of medicine. Of course, he asks whether Mihai smokes and uses any other drugs – but he has to, right? At first, Mihai finds himself denying using drugs, but later admits to using for two years when Dr DM takes his blood pressure and notices scars on his arm. In the end, Dr DM suggests that Mihai gets a chest x-ray and test for tuberculosis and consider an HIV test.

It's a few weeks before Mihai goes back. He's scared, but eventually he decides to get the tests that Dr DM recommended. It's free and they were nice. He's surprised about the results. The HIV test was negative, but Mihai is diagnosed with tuberculosis. Mihai always thought you only had tuberculosis if you coughed all the time.

Together, Dr DM and Mihai come up with a treatment plan that works for Mihai. He's introduced to a community worker who will help him remain compliant with the medications and he will continue to see Dr DM for regular check-ups. Mihai feels for the first time in several years that someone is interested in his

welfare and that together, with help from Dr DM and the community workers, he may be able to improve his health and maybe even get a job.

Dr SM has a lot of work experience. She specialized in gynaecology in Romania, received additional training while there and developed many ideas about how to improve gynaecology services in the Republic of Moldova. She knew in advance that it would not be easy and that she would have to work as a volunteer, fighting against the suspicions of colleagues. It would be much easier if she left and went abroad as a lot of her colleagues had done, but she wanted to stay and make things “better”.

For five years, Dr SM has worked voluntarily trying to improve the health of adolescents and young people. Her first step was to go to the local high schools in the hope of finding out what young people needed. She also hoped to recruit her first volunteers. She was surprised by how many people were interested. In the end, Dr SM decided to choose people who listened as well as asked a lot of questions. She trained them to be peer-educators and hoped they would be able to train their peers in good health communication skills.

The efforts of Dr SM have slowly paid off. Based on positive feedback from Moldovan youth using her service, the hospital management and donor organization decided to create a youth health centre. Ten years on, the centre is thriving. All facets of the community support the project and volunteering at the centre is now popular among young people, both as a marker of social status and as a good reference for later employment. The centre has also expanded services to other districts, facilitating a “healthy-peer” network and a disability health service, and annual meetings are held with the association of Gagauz women.

Ten years on, Dr SM is glad she chose to stay in the Republic of Moldova. Her dream has become a reality, but there are still problems. She works hard to earn enough for her and her family. Low salaries force her to work two or three jobs at a time and her working day is rarely finished before 20:00. But it has been worth all the pain. Her greatest satisfaction comes from the youth volunteers. There are those that regularly attend the centre, working hard and calling her “mother”; every day, five adolescents who would otherwise go without come to the centre in search of contraception. She knows that adolescents and young people, healthy or not, are all around us and need support and help. If they do not have enough confidence to come and address their problems with health professionals, we have to find ways to attract them.

Dr SM is not an isolated example of medical doctors in the Republic of Moldova holding two or three jobs at the same time. Almost all doctors have a permanent main state job and are allowed to have two or three other jobs, meaning they may do a few hours in a state setting then work in the other places, bringing them a total salary of 125%. Many also work in private clinics to increase their base salaries.

Appendix 3. Standards of quality

Standard 1. Young people know when and where to ask for health services

| Input criteria | Process criteria | Output criteria |
|---|---|--|
| I1. The job descriptions of the health service providers and the support staff to be posted in the institution include health promotion. | - | 01. Young people in the community are aware of the availability of quality health services at service delivery points. |
| I2. The institution has a plan for its staff to conduct visits to schools in the catchment area to inform teachers about the availability of quality health services for young people. | P2. Visits to the schools are carried out according to plan. | |
| I3. The institution has a plan for its staff to visit organizations working with groups of young people at risk, to inform them about the availability of quality health services for young people. | P3. Visits to the organization are carried out as planned. | |
| I4. The institution has a plan to meet with youth groups in the catchment area to inform them about the availability of quality health services for young people. | P4. Meetings with the youth groups are carried out as planned. | |
| I5. Information boards are put up at service delivery points. | - | |
| I6. Information materials about the work of the delivery points are available for distribution. | P6. The information materials are distributed during visits to schools and organizations working with young people at risk, as well as in meetings with youth groups. | |

Proposal for limited monitoring: I1/I2 and P2/I6 and P6/in coverage tool – 01.

| Standard 2. Young people have easy access to the health services they need; they also find them acceptable | | |
|--|--|--|
| Input criteria | Process criteria | Output criteria |
| I1. There are policies and procedures in place guaranteeing that health services are free or affordable to all young people. | | <p>01. Young people in the community are aware of the availability of quality health services at service delivery points.</p> <p>02. Young people find service delivery points friendly.</p> |
| I2. The institution is located in a place which is both easy to reach and discrete. | | |
| I3. The working hours of the institution are flexible. | P3. Health services are provided in the morning and afternoon, with or without prior appointment. | |
| I4. Policies and procedures guarantee that young people can come to the institution themselves or with referral. | P4. Health services are provided to young people themselves as well as those who are referred. | |
| I5. Mechanisms are in place to ensure the following minimum conditions in the institution: <ul style="list-style-type: none"> • the rooms are clean; • lighting, ventilation and heating systems are operational; • drinking water is available; • toilets are present and functional; and • information materials are available at reception and in waiting rooms. | P5. Health facilities meet the specified conditions. | |
| I6. Staff in the institution have the competencies to provide health services in the language used by the young people in the community, and to use formulations they understand. | P6. The staff communicate to young people in the language they know, using formulations they understand. | |
| I7. The service delivery point has a telephone line for young people to call for information. | P7. Young people call on the telephone line for information. | |
| I8. The service delivery point has well-displayed information about pricing policies and procedures in place. | P8. Young people are informed about pricing policies and procedures in place. | |
| <p><i>Proposal for limited monitoring: I1 and P1/I5 and P5/coverage tool: O1 and O2.</i></p> | | |

Standard 3. Health service providers maintain the confidentiality and respect the privacy of young people

| Input criteria | Process criteria | Output criteria |
|--|--|---|
| I1. The institution has clear procedures to ensure the confidentiality and privacy of young people, except in specific situations which are stipulated in the law. | - | <p>O1. The confidentiality of young people is ensured.</p> <p>O2. The privacy of young people is respected.</p> |
| I2. Health service providers are aware of the procedures on confidentiality and privacy of young people. | P2. Health service providers ensure the confidentiality and respect the privacy of young people in line with the procedures. | |
| I3. Auxiliary staff are aware of the procedures on confidentiality and privacy of young people. | P3. Auxiliary staff ensure the confidentiality and respect the privacy of young people in line with the procedures. | |
| <p>I4. The staff responsible for establishing, maintaining and retrieving the records are aware of the procedures on ensuring the confidentiality and privacy of young people in:</p> <ul style="list-style-type: none"> • codifying the records • holding the records safely. | P4. The staff responsible for establishing, maintaining and retrieving the records follow these procedures. | |
| I5. The premises of the institution (the reception, waiting area, consultation and examination room) are organized to ensure the privacy of young people (and specifically to prevent the presence of those who do not need to be present). | P5. Health service providers and support staff follow the procedures on ensuring the privacy of young people in the consultation and examination room. | |

Proposal for limited monitoring: I1/I2 and P2/I5 and P5/coverage tool: O1 and O2.

| Standard 4. Health service providers mobilize the community (to promote youth friendly health services) | | |
|--|--|---|
| Input criteria | Process criteria | Output criteria |
| I1. The regulations of the institution providing YFHS and job descriptions of the relevant staff contain community mobilization activities for YFHS promotion. | | <p>O1. Community members, especially parents of adolescents, support the provision and use of YFHS, especially for sexual reproductive health issues.</p> <p>O2. Adults working with young people in the community are aware of the availability of quality health services at service delivery points.</p> |
| I2 Promotion of adolescent health and YFHS is included in the work plans of local, rayon, and municipal councils. | P2 Local, rayon and municipal councils contribute to the promotion of adolescent health and YFHS through their work plans. | |
| I3. Information materials for different community members are available at the health facility. | P3. Information materials for different community members are distributed. | |
| I4 Mechanisms exist to collaborate with local media. | P4. Health service providers participate in local media shows and in local health promotion activities on the health of young people, in line with the plan. | |
| I5.1 Links with schools in the catchment area have been established for health providers to participate in parents' meetings. I5.2 A plan for participation in meetings has been developed. | P5. Health care providers participate in parents' meetings at school to inform parents about the health problems of young people and health services for them. | |
| <p><i>Proposal for limited monitoring: I1/I2 and P2/I5 and P5/coverage tool: O1 and O2.</i></p> | | |

Standard 5. Health service providers provide health services effectively, in line with the minimum or extended package

| Input criteria | Process criteria | Output criteria |
|---|---|--|
| I1. The institution providing YFHS has a staff list that complies with the requirements for delivering the minimum or extended package of health services. | P1–8 Health service providers undertake case management in line with standard operating procedures. | Health service providers provide effective health services in line with basic (minimum) or extended package. |
| I2. The institution has staff in place in line with the staff list. | | |
| I3.1 The staff have the clinical competencies required to provide the minimum or extended package of health services. I3.2 The staff have the communication competencies required to provide the minimum or extended package of health services. | | |
| I4. The institution has mechanisms for continuing education of staff. | | |
| I5. The institution has evidence-based protocols for the provision of the minimum and extended package of health services. | | |
| I6 Staff are trained to take an integrated approach to the problems of young people (diagnosis, treatment, education and counselling, and referral where needed). | | |
| I7 Staff are trained to deal with adolescents in a comprehensive manner, taking into account their physical, psychological and social needs. | | |
| I8 Staff know how to involve young people in their health and development. | | |
| I9. The institution has guidelines for referral of patients to other health and social service providers. | P9. Health service providers refer patients in line with these guidelines. | |
| I10.1 The institution has the necessary equipment to provide the minimum or extended package of health services. I10.2 The institution has the necessary supplies, including contraceptives to provide the minimum or extended package of health services. | | |

Proposal for limited monitoring: I1/I3.2 and P3.2/I5 and P5/I10.1–10.2 and P10.1–10.2.

Standard 6. All young people have equal access to health services

| Input criteria | Process criteria | Output criteria |
|---|--|---|
| <p>I1. There are clear legal and regulatory procedures to ensure equitable access of young people to health services irrespective of sex, age or social status.</p> <p>I2. Health service providers and support staff are aware of these laws and procedures.</p> | <p>P1–2. Health service providers and support staff provide health services equitably irrespective of sex, age or social status.</p> | <p>All young people have equal access to health services.</p> |
| <p>I3. There are procedures in place to provide young people without insurance with health services free of charge.</p> | <p>P3. Health services are provided free of charge for young people without health insurance.</p> | |
| <p>I4. The physical conditions of the institution are adapted to ensure that disabled young people can use them (such as the provision of wheelchair ramps).</p> | | |
| <p>I5. There are procedures in place for the anonymous delivery of health I6. The institution has a plan for outreach health promotion activities to be provided by both staff and volunteers to most-at-risk young people.</p> | | |
| <p>I6. The institution has a plan for outreach health promotion activities to be provided by both staff and volunteers to most-at-risk young people.</p> | <p>P6. Outreach health promotion activities are carried out by both staff and volunteers to most-at-risk young people.</p> | |
| <p><i>Proposal for limited monitoring: I1 and P1/I2 and P2.</i></p> | | |

Russian Federation: youth-friendly health services

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Executive summary

The Russian Federation faces a demographic crisis, with an average population decrease of 700 000 people per year.

Child and adolescent mortality rates give cause for concern. External causes of mortality dominate in all age groups of children and adolescents, with a sharp increase seen in the 15–19 age group. The mortality rate due to external causes for this group in 2005 (including suicide) was 85.8 per 100 000, with a suicide rate of 19.6 (1). Analysis of adolescent mortality reveals that 75% of all deaths were preventable as they were caused by chronic diseases (20%), substance misuse/poisoning (6%), alcohol poisoning (5%), accidents (34%), suicide (30%) and unknown causes (5%).

Prevention strategies and health promotion interventions are needed to reduce morbidity and mortality and to enable children and young people to develop into healthy, contributing adults. They are also crucial in safeguarding the reproductive health of young people.

While the government has identified young people’s reproductive health as a priority, health care and education systems are not yet properly equipped to address their specific needs. To bridge the gap between the health needs of young people and existing health care services, the Ministry of Health and Social Development of the Russian Federation and the United Nations Children’s Fund (UNICEF) Russian Federation have developed and promoted the concept of integrated youth-friendly health services, a model that provides young people with an easily accessible range of age-appropriate health, social, psychological and information services.

To date, 117 youth-friendly service facilities have been established in 28 Russian Federation regions. They provide reproductive, sexual and mental health services to approximately 1.5 million young people.

A two-pronged strategy is being pursued, through which UNICEF supports field-level efforts to establish youth-friendly health services in line with international standards and adapted to local circumstances, while at the same time investing in the capacity-building of relevant professional communities throughout the Russian Federation.

Youth-friendly health services provide a tried and tested way of promoting better health among young people and their families. With relatively limited funding, effort and time, youth-friendly health services can be made available to young people throughout the country. UNICEF expects that over time, they will contribute to safer and healthier behaviour among adolescents and young people, reducing the dramatic health statistics and mortality rates that underlie the Russian Federation’s demographic crisis.

Background

Economic, sociocultural and demographic context

As of 1 January 2009, the Russian Federation had a population of 141.9 million (2). While ethnic Russians account for about 80% of the total population, over 160 nationalities are also represented.

About 73% of the population is classified as “urban” and live in the country’s 1066 cities and 2270 urban settlements, children and young people aged 0–19 years account for approximately 22% (31 million at 1 January 2008).

The Russian Federation consists of 83 self-governing constituent units (*subjects*), including 9 territories (*krais*), 46 regions (*oblasts*), 21 republics, 2 cities of federal importance, 1 autonomous region (*autonomous oblast*) and 4 autonomous areas (*autonomous okrugs*). The cities of Moscow and St Petersburg are considered constituent units (*subjects*) in their own right. In addition, the Russian Federation territory is also divided into 7 federal districts for administrative purposes.

The 83 constituent units differ substantially in terms of natural resources, economy and geography. They also tend to be extremely diverse within themselves: for example, regional centres often have a developed labour market and infrastructure, while small towns and rural areas have low income levels, much lower living standards and limited education and recreational facilities, restricting young people’s development opportunities.

The Russian Federation’s economy grew by 7% a year from 1999 to 2007, and this trend continued in the first half of 2008, with an 8% increase. Poverty fell to 14.7% in the first half of 2008 (from 29% in 2000), with approximately 30 million people moving out of poverty between 2000 and 2007. However, the global financial crisis has posed new challenges for the Russian Federation’s macroeconomic and social policies. Over the last quarter of 2008, the economy experienced a gradual slowdown which resulted in a gross domestic product (GDP) growth of 6% for 2008, compared to 8.1% in 2007.

While substantial financial reserves protected the Russian Federation from feeling the full impact of the crisis in late 2008, a recession started in 2009. This has already led to a budget deficit and the scaling-down of socioeconomic programmes. These conditions have caused losses in real incomes and employment and a rise in poverty. Though there are as yet no reliable data on young people’s unemployment rates, it is presumed that the consequences of the economic crisis will significantly affect job opportunities for this population group.

Tackling the Russian Federation’s demographic crisis continued to be a national policy priority throughout 2008. The child population decreased by 5 million between 2002 and 2007, with the falling trend continuing in 2008 (Fig. 1). Monetary benefits introduced to improve the living standards of families with children and to encourage them to have more children have, however, contributed to sustaining a slow but positive growth in the birth rate: the number of births increased by 8.8% in 2007 and by 6.6% in 2008, but the 2008 birth rate of 12.1 births per 1000 population was still lower than the death rate (14.6 deaths per 1000 population). Consequently, the population decline continued (Fig. 2).

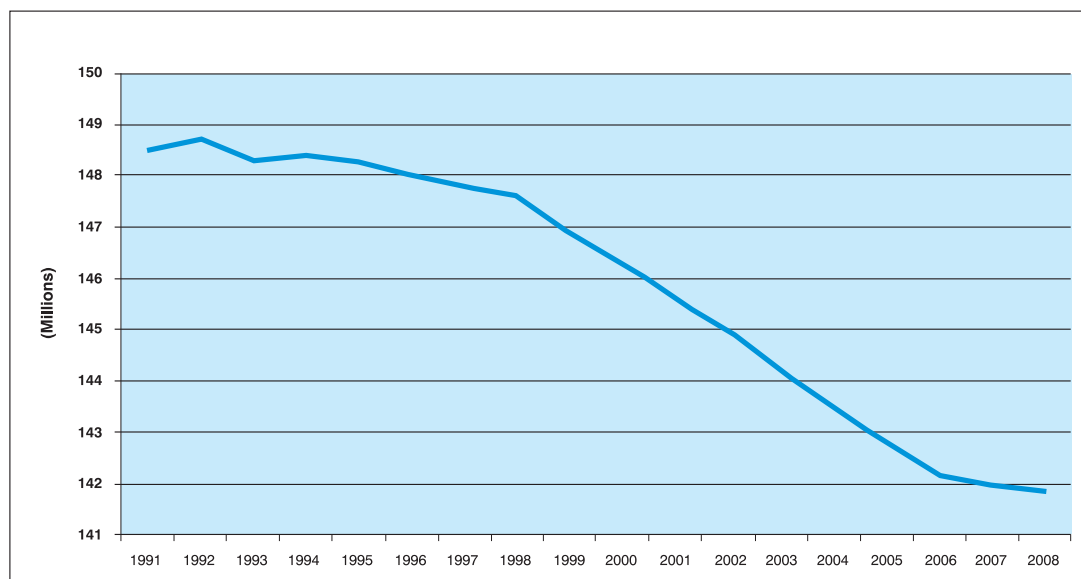
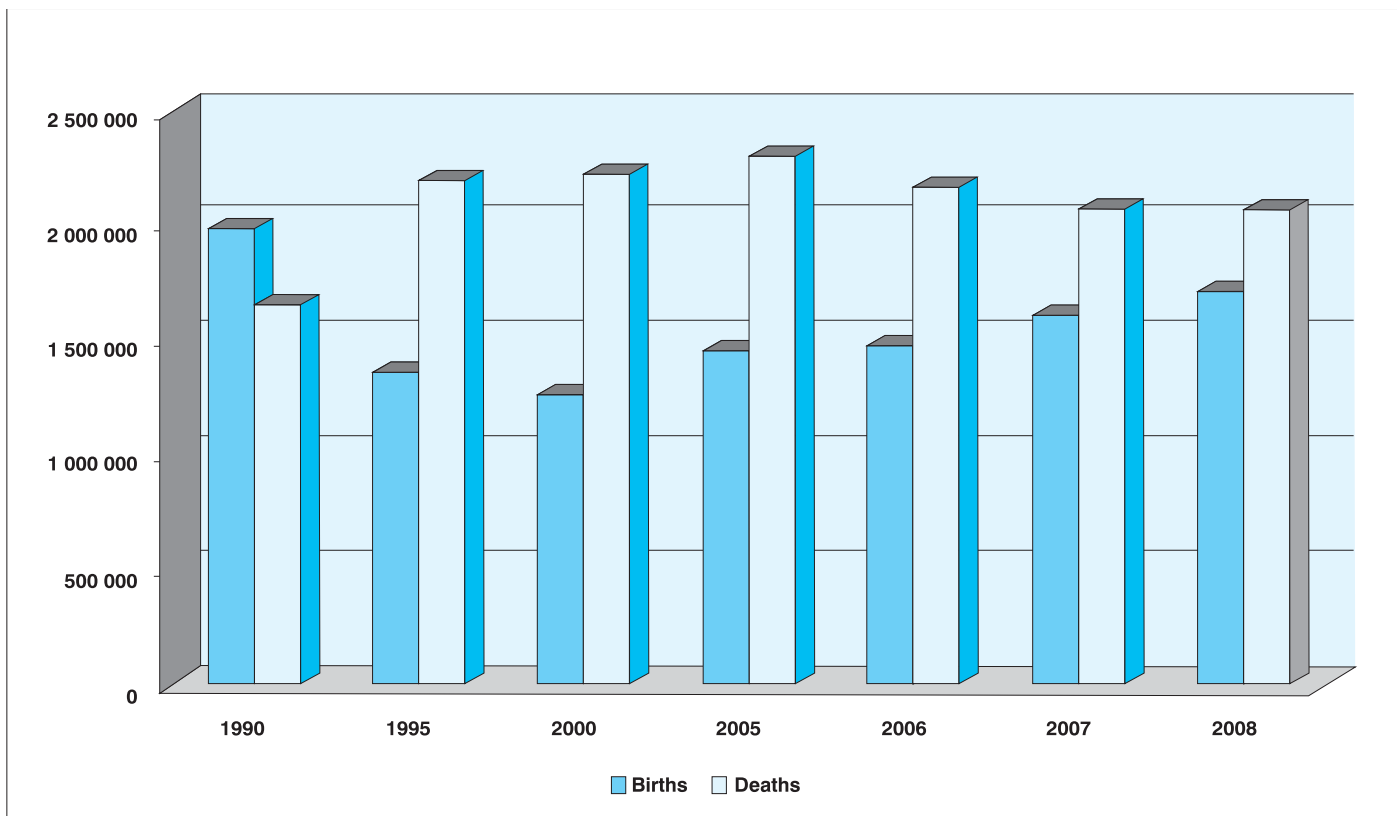


Fig. 1 Population of the Russian Federation, April 2008

Source: Rosstat,⁸ April 2008

⁸Rosstat, the State Committee on Statistics of the Russian Federation, is the country’s main statistical agency.



Source: Rosstat, April 2008

The Russian Federation's child and adolescent mortality rate (0–19 years) is 75.7 per 100 000 children, almost four times higher than that for western European countries (3).

In 2005, mortality due to external causes for 15–19-year-olds was 85.8 per 100 000, with a suicide rate of 19.6 per 100 000. Analysis of adolescent mortality reveals that 75% of all deaths were preventable as they were caused by chronic diseases (20%), substance misuse/poisoning (6%), alcohol poisoning (5%), accidents (34%), suicide (30%) and unknown causes (5%). The major groups of diseases leading to the high mortality rate in this age group are determined by adolescent risky behaviours.

The priority health and development needs of young people

On the whole, families with children face greater risks of poverty, with children's risk of poverty being almost twice as high as the general population (4). They have faced great economic difficulties and stress over the past 20 years, which has resulted in an increased incidence of family breakdown and greater numbers of children being forced into vulnerable situations. Children's increased vulnerability is also fed by a high divorce rate. While Rosstat figures show that the divorce rate decreased to 4.2 per 1000 people in 2005, the problem remains traumatic for the children and young people affected.

Substance misuse is another factor that contributes to family breakdown. According to a 2002 study by the Moscow nongovernmental organization (NGO) "No to Alcohol and Narcotics Addiction", parental alcoholism was the main reason for delinquency in children, comprising 71% of the two-parent families surveyed (5).

Domestic abuse and violence remains a serious problem affecting the life perspectives of children and young people. National statistics on abuse towards children provide some indication of the scale of this problem. Every year in the Russian Federation, approximately 15 000 minors under 14 years die. Fifty per cent of them die from unnatural causes, with more than 2000 dying as a result of murder or severe physical abuse. These deaths are frequently the result of failure of parental care and supervision (6).

The current generation of young people are living through an unprecedented period of extraordinary change

and uncertainty and are ill-equipped to deal with the emerging challenges. Risky behaviours, reflected by an increase in the rates of tobacco, alcohol and drug abuse, frequently lead to accidental and violent death, including suicide. The prevalence of alcohol use among 15-year-olds is believed to be 30%, and the rate of cigarette smoking is 33%. Experts estimate that the Russian Federation ranks fourth in the world in terms of tobacco consumption among this age group.

Results from a survey of boys' attitudes to risky behaviours (7) are shown in Table 1. For girls, risky behaviours frequently result in unwanted pregnancies.

Table 1. Boys' risky behaviours (7)

| Risky behaviour | 16 years | 18 years |
|--|-----------------|-----------------|
| Regular smoking (up to one pack per day) | 9.5 % | 26.9 % |
| Alcohol use (up to four times per month) | 19 % | 23.1 % |
| Tried drugs | 9.5 % | 7.7 % |
| Used drugs | 9.5 % | 3.8 % |
| Sexually active | 42.9 % | 65.4 % |

In the Russian Federation, as in the rest of the world, young people are disproportionately affected by HIV, with 73% of people living with HIV being diagnosed when they were between the ages of 15 and 30 years. A total of 54 046 new cases of HIV infection were reported in the Russian Federation during 2008, 20.6% up on the figures for 2007. By the end of the year, the total number of people in the Russian Federation known to be HIV infected reached 470 985, of which 34 865 had died and 436 120 were living with HIV (no age and sex disaggregated data on new cases of HIV are available from published sources).

Unsafe drug use remains the main mode of HIV transmission (63% of infected people are injecting drug users), but heterosexual transmission is growing rapidly (approximately 35% of all cases with established mode of transmission in 2008, versus 20% in 2002). According to the head of the Federal Narcotics Control Service (FSNK), there are 2.5 million addicts and more than 5.1 million drug users in the Russian Federation, almost double the 2002 figure. Heroin and other opiates predominate; the proportion of people in the Russian Federation using opiates is the highest in the world for countries with populations larger than 100 million, and five to eight times greater than the European Union (EU) average.

On 4 July 2009, President Medvedev told a youth forum that drug addiction, along with alcoholism and smoking, represented a serious threat to the Russian Federation's future. He noted that 40% of the country's young people smoke and that average per capita alcohol consumption has reached the equivalent of 18 litres of pure alcohol per year – twice the level at which serious medical and genetic damage become apparent. The FSNK estimates that 10 000 people in the Russian Federation die each year through overdoses and that another 70 000 deaths are drug-related; however, the FSNK head recently suggested that the actual overdose toll may be as high as 30 000.

Deaths from these causes are disproportionate among young men (the average age is 28 years) (8).

Since the early 1990s, the adolescent suicide rate has increased by 28.2% among boys and by 9.2% among girls (9). Experts estimate the level of depression among adolescents in the Russian Federation to be about 20%.

The issue of adolescent pregnancy in the Russian Federation causes concern. Between 2000 and 2004, there was an 11.7% increase in the number of births among girls aged 17 years or younger. That equates to 41 159 births in 2004 compared to 36 831 in 2000 (10). The majority of these births were among 16- and 17-year-olds who face greater medical risks and are likely to be less psychologically prepared to care for a child. Since pregnancy among adolescents is more frequently accompanied by complications, the chances of maternal mortality in this group have grown dramatically.

The situation regarding abortions among adolescent girls also warrants concern (Fig. 3) (11). Rosstat figures for 2004 (the most recent year for which official data are available) show that the rate of abortions performed for 15–19-year-old girls was 29 per 1000. For those under 15 years, the figure was 0.1 per 1000. Although the number of abortions among 15- to 19-year-old girls is falling, the rate for those under 15 has risen in recent years. While estimates differ, it seems that around 10% of abortions are performed on girls under 19 years, and about 88% of pregnancies in girls under 15 years end in abortion (6).

Experts from the Russian Federation offer no single explanation for the decrease in the number of abortions, but among the most common reasons cited are a general increase in contraceptive knowledge and underreporting of abortions carried out in commercial medical centres, who very often do not submit accurate data on abortions to state health agencies.

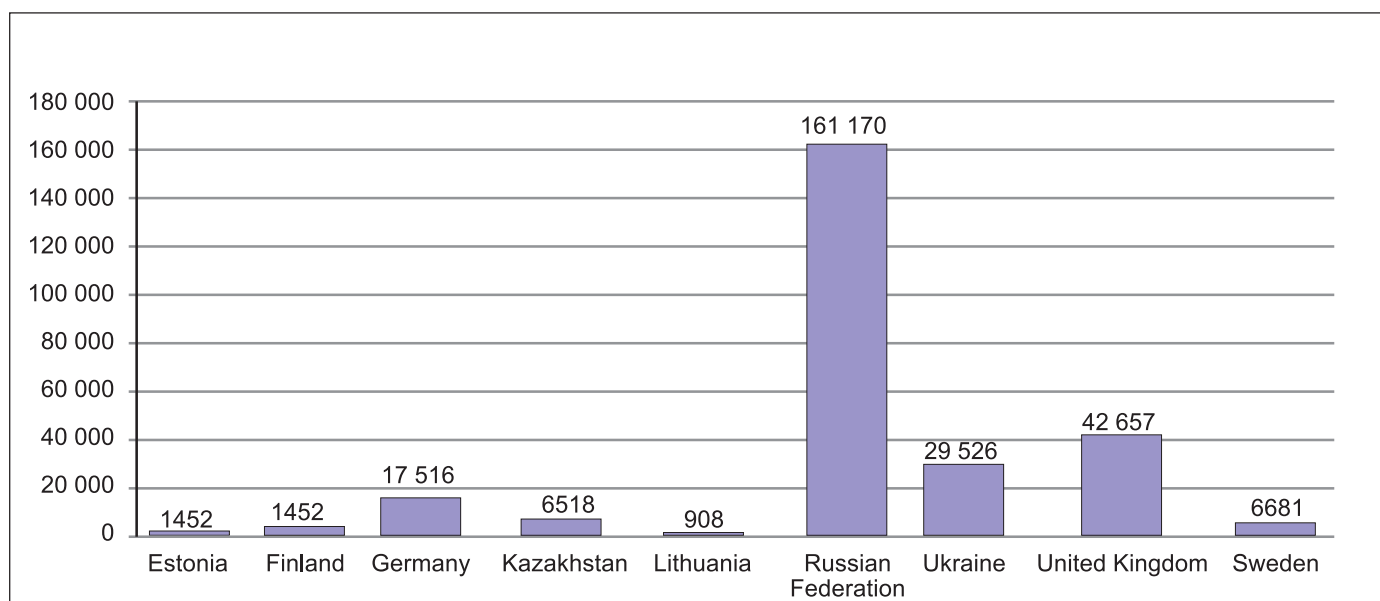


Fig. 3 Number of abortions, age under 20 years (2004) (11)

Health system context and health services available for young people: organization of health care

Until recently, the Russian Federation’s health care system was resource-based rather than results-based, which translated into an emphasis on curative rather than preventive responses. The development of public health policies and strategies is progressing slowly and remains a challenge.

The Russian Federation Government’s national project priority of modernization of health care has the potential to significantly improve children’s and young people’s health. The programme focuses on making primary health care more accessible and of better quality. The federal programme “Children of Russia” also has a key component (“Healthy generation”) in its 2007–2010 plan that focuses on health. Objectives for this project include guarantees on safe maternity care and healthy childbirth, protection of children’s and young people’s health, including their reproductive health, and prevention of child and adolescent illnesses, disabilities and deaths.

Until 1999, children were seen at children’s outpatient polyclinics until the age of 15 and were then moved on to adolescent departments of adult clinics. One of the first decisions made by the Ministry of Health as part of reform of the provision of medical services for young people was to keep children at children’s polyclinics until the age of 18. These children’s polyclinics provide free services for the child population living in the catchment area, providing they have valid compulsory medical insurance. Children’s polyclinic doctors (neuropathologists, oculists, ear, nose and throat specialists, urologists, surgeons, children’s and adolescents’ gynaecologists, cardiologists, endocrinologists, etc.) diagnose and treat acute diseases and monitor the health of children with chronic pathologies. Polyclinics also perform laboratory analyses for children, including for HIV infection.

Family medicine is currently provided by family doctor offices that may be located either within adult polyclinics or as separate entities. They are not yet widespread in the country and have proved inefficient in meeting adolescent-specific health needs.

Adolescents tend to be caught between these two elements of the health care system, their needs considered beyond the scope of each. The transfer of 15–18-year-olds to the paediatric network essentially did not alter the situation in relation to adolescent reproductive health. Health care for adolescents is provided by paediatricians in local children's polyclinics, but their counselling approaches tend to be tailored towards the needs of young children. With an average of 12 to 15 minutes for each patient, doctors are not able to address adolescents' specific counselling needs. Adolescents who have had long-term relationships with their local paediatricians are often embarrassed to discuss difficult issues such as contraception or sexually transmitted infections (STIs), and may also worry about breaches of confidentiality.

School medicine, as part of primary health care, is supposed to provide (in close cooperation with children's polyclinics) a range of preventive services for children and adolescents of school age. In reality, however, the overwhelming majority of school medical units have a deficit of medical professionals and, as a rule, are staffed by paramedical personnel who deal mainly with vaccination and monitoring the quality of school food.

Specialized reproductive and sexual health services for adolescents and young people are also provided by a number of state health institutions: dispensaries (dermatovenereological, narcological), maternity clinics (girls' reproductive health, pregnancy and childbirth), family planning and reproduction centres, and AIDS and infectious disease prevention centres. Despite their offer of free testing, diagnostic and treatment services, these health institutions are not attractive to the majority of adolescents and young people.

Socially vulnerable categories of young people (drug users, commercial sex workers, unsupervised and street children) have the same rights as other groups of the population, but in reality they have very limited access to health services, with the exception of those provided by NGOs.

A question that often arises is whether special services for young people are really necessary when there are medical institutions all over the country that serve both adults and children. The statistics show, however, that the average age for adolescents to become sexually active is decreasing, the numbers of STIs and early pregnancies are increasing, drug abuse, smoking and alcoholism are spreading, young people are becoming involved in the sex industry and the HIV/AIDS epidemic continues. Adolescents are not welcome visitors at regular clinics; they are considered by staff to be unreliable, financially insolvent and "peculiar" in their ways. And young people themselves are not very willing to come to regular medical institutions – they do not want to be treated coldly and with indifference and are wary of confidentiality issues (summary results of UNICEF Russian Federation partner organization surveys, polls, questioning and focus groups with adolescents, unpublished data, 2009).

In general, the health care system as it is today is not equipped to address the specific needs of adolescents and young people in the area of reproductive and sexual health, mental disorders and risky behaviour prevention. Available health services are mainly disease-oriented and there are no comprehensive primary care-level services that address both prevention and treatment. The inability of health services to meet adolescent health needs often results in adolescents failing to seek necessary treatment or counselling and being unwilling to expose themselves to criticism or stigma.

Financing

While private medical institutions exist, the Russian Federation medical system is mostly free and is available to anyone who has the so-called "mandatory medical insurance" (MMI). The system of MMI covers most of the state medical institutions; any citizen of the Russian Federation can receive MMI in the district of his or her permanent residence. At the same time, people can use the services of private medical

insurance companies and medical institutions.

The types and scope of medical care provided free of charge to the population of the Russian Federation (including children and adolescents) are outlined in the “Programme of state guarantees for the provision of free medical care to citizens of the Russian Federation in 2005”. The programme is financed out of budgets at all levels (federal and municipal) and by mandatory medical insurance contributions and other revenues.

Under the programme, children, adolescents and young people can receive the following types of assistance free of charge:

- medical assistance provided at specialized medical institutions for, for example, STIs, tuberculosis, AIDS, psychological disorders and behavioural disorders, and drug-related diseases (financed out of the budgets of the constituent entities of the Russian Federation);
- STI and unwanted pregnancy prevention, contraceptive help (both counselling and contraceptives), HIV and STI testing at outpatient and inpatient facilities of polyclinics and hospitals (financed out of the budgets of municipalities, primary medical services and sanitary assistance); and
- regular preventive health checks for all children and adolescents, including those who are healthy, assistance during pregnancy, birth and the perinatal period, and abortion services (financed out of the basic MMI programme).

The list of health care services covered out of state budgets is wider than the list covered out of MMI: for instance, MMI does not cover services that are crucial in working with adolescents and young people, such as psychological counselling and social support. There are also difficulties in serving the reproductive and sexual health needs of adolescents and young people.

The lack of or shortage of budgets and financing from MMI contributions alone can reduce the scope of services available to adolescents. Free HIV and STI testing is available only within budget financing and is mainly provided by specialized institutions that are not considered attractive by young people, for reasons cited above. Also, the programme of state guarantees does not include the provision of preventive services (including contraceptive assistance, HIV and STI testing) outside treatment institutions; consequently, outreach activities are not financed by the state and can be implemented only through off-budget sources. This means that very often, socially vulnerable groups of adolescents and young people, including commercial sex workers, homeless children and adolescents and drug users – categories of the population that normally do not visit health institutions – remain beyond the reach of health services.

MMI policy makes it difficult to observe the principle of anonymity in dealing with patients who want to be tested for STI and HIV. Services can be provided to patients free of charge only if they present their passport and insurance policy and testify that they are resident or studying in the district covered by the given institution. In the absence of these documents, services can be provided only on a payment basis. The same factors also reduce the coverage and scope of assistance provided to children from socially disadvantaged populations, who often lack the necessary documents and are not covered by district treatment and prevention institutions.

Human resources for young people's health

In the Russian Federation, there are 47 medical universities and institutions (high schools) with a capacity of around 25 000 graduates each year. Although some aspects of adolescent health are covered within paediatric courses, there is no special “adolescent medicine” training course. Opportunities to access postgraduate education in adolescent medicine are also very limited.

There is only one adolescent medicine department in the Russian Federation, based at the Medical Academy of Postgraduate Studies in St Petersburg. This department delivers two special courses: “Medical and social services for adolescents” (72 academic hours), and “Adolescent reproductive health and sexuality” (72

academic hours). Consequently, the majority of the 55 000 paediatricians in the Russian Federation, as well as other medical specialists dealing with adolescents and young people, have extremely limited postgraduate training opportunities in adolescent health.

Policy context

In general, the current Russian Federation legislative base is favourable to meeting adolescents' and young people's health needs, enabling delivery of various services and interventions. It guarantees that comprehensive assistance is provided to the adolescents and young people of the Russian Federation to preserve their health, including reproductive and mental health aspects. In addition, the state guarantees that adolescents and young people will receive, on a level equal to that of older adults, free, accessible, voluntary and quality support in family planning, contraception and the diagnosis and treatment of STIs (including HIV infection).

The most important regulatory documents in relation to adolescent health and youth-friendly health services are summarized below.

The Russian Federation Law no. 5487–1, on Protecting Citizens' Health, dated 22 July 1993, Article 61. Confidentiality and medical secrets

The general rule is that the contents of a child's medical record are a medical secret; the information therein may be transmitted to no one without the patient's consent (that is, the consent of a child of 15 years and over and the consent of the parents or legal representatives of a child under the age of 15 years).

The Russian Federation Law no. 5487–1, on Protecting Citizens' Health, dated 22 July 1993, articles 32–34. Consent to medical intervention

Minors of 15 years and over have the right to give voluntary informed consent to, or to refuse, medical intervention, including the right to demand that the doctors provide information on the state of their health. The same articles guarantee the right of adolescents of 15 years and over to abortion services without parental or legal representatives' consent.

Order of Russian Federation Ministry of Health no. 154, dated 5 May 1999, on Improving Medical Assistance to Adolescent Children

In the Russian Federation, activities on developing sociomedical services for children and adolescents are carried out by government health care agencies, with the assistance of the UNICEF Russian Federation Office. In recognition of the need to change the system of medical care for young people, and of the need to take special measures to protect the reproductive health of adolescents, the Ministry of Health of the Russian Federation issued this special decree in 1999. This served as an important entry point in developing a system of medical and social support services for adolescents which aimed to bridge the gap between adolescents' health needs and the Russian Federation's existing health care services.

Youth-friendly health services approach

UNICEF, as a main partner of the Ministry of Health in the area of children's and young people's health care, supports government efforts to protect young people's health and has developed and promoted an integrated youth-friendly health services model that provides young people with an easily accessible range of age-appropriate health, social, psychological and information services. Complementing these activities, UNICEF has also promoted youth-friendly health services on a national scale in close collaboration with federal and regional health and social protection authorities and institutions, advocating for systemic reform from a curative to a more preventive health care approach.

Planning evidence-based interventions

In 1999, the UNICEF Russian Federation Office introduced the youth-friendly health service concept to Russian Federation medical professionals, who clearly understood the need to provide adolescent-focused health services.

A project on “Improving reproductive health services for adolescents in the Russian Federation” was launched in 1999 in cooperation with the Association for Voluntary Surgical Contraception (AVSC) International. The aim of the project was to make sure that the UNICEF programme had enough information on existing needs and available resources to deal with the challenge of promoting the development of youth-friendly health services in the country. Four locations were selected for the project inception phase – Kaliningrad Centre for Medical Prevention, Moscow South-west District Diagnostic Centre for Teenagers, the Russian Family Planning Youth Centre in Moscow, and the St Petersburg “Yuventa”.

Project activities included focus group research with adolescents and in-depth interviews with service providers, and a series of seminars based on the research results was held. Topics covered during the seminars included: details of the youth-friendly health service, counselling on STIs, the “COPE” (“client-oriented, provider-efficient”) exercise on quality improvement, and the training of facilitators who would be able to train service providers on youth-friendly health services at the end of the project. The project provided UNICEF with better knowledge of the then-current situation; it identified existing gaps and needs and helped to mobilize the first group of qualified trainers.

Building upon local medical expertise in St Petersburg, UNICEF served as a catalyst to develop a concept of youth-friendly health services aimed at enabling adolescents and young people to receive specialized medical, psychological and social help in solving adolescent-specific health problems and in preventing various diseases. Youth-friendly health services also aim to assist adolescents to understand their problems and work with them to change their behaviour patterns to better preserve their health. Implementation of peer outreach and counselling within the services has been a critical component of the model’s success.

Support and advocacy for the model

The development of youth-friendly health services depended upon engagement with, and capacity-building support from, government services, NGOs and academic institutions. Interventions were tailored through ongoing analyses of legislative frameworks, existing needs and available resources, and the dissemination of the outcomes of adolescent focus groups and in-depth interviews with services providers, officials and national working groups.

In parallel with the development of a tested youth-friendly health services model, UNICEF conducted multilevel advocacy to attract official recognition of (and support for) this innovative programme to try and ensure nationwide expansion. Effective advocacy at regional and federal levels has required extensive dedicated time from UNICEF in building working relations and trust among government colleagues. Demonstration of the model’s successes has been critical in raising policy-makers’ understanding and gaining their buy-in. Ongoing dialogue with regional and federal government colleagues has also been critical in enabling UNICEF to react quickly to political opportunities.

Supporting field-level efforts

Development and implementation from the very beginning followed a two-pronged strategy, in which investment was made in building capacity in youth-friendly health services expertise within academic communities throughout the Russian Federation while field-level efforts to establish youth-friendly health services in line with international standards (adapted to local circumstances) were pursued.

UNICEF’s assistance in supporting the establishment of youth-friendly health services in different territories of the Russian Federation has included:

- developing agreements, statutes and protocols governing the establishment and functioning of the clinics;
- conducting training courses and supporting internships on youth health needs for health professionals working in the clinics;

- conducting training courses on peer education and counselling for young volunteers;
- providing necessary equipment and supplies for the clinics;
- developing culturally- and age-relevant information materials for the clinics; and
- advocating, based on the experience in the pilot cities, for the establishment of a network of youth-friendly clinics throughout the country.

Scaling-up of the youth-friendly health services model requires a well-balanced combination of providing support to regions interested in establishing services and working to strengthen initiatives at national level. Since the project was launched, UNICEF has provided technical and methodological support to regions that expressed interest in applying a youth-friendly approach for the provision of medical and social services to young people.

Normally, establishment of youth-friendly health services involves direct government buy-in, starting with an “orientation meeting” in which the regional administration is involved in defining the number and locations of prospective youth-friendly health services. Young people are also involved in the design of youth-friendly health services and take part in joint training with specialists; this ensures that young people’s voices and perspectives are effectively included from the beginning.

Networking approaches proved to be much more effective in establishing a new type of adolescent health service; they enabled the issues raised when several project locations, usually representing different settings (urban, rural, mobile, etc.) are defined and involved in implementation to be identified and tackled.

Youth-friendly health services models

UNICEF has tested and implemented different formats of youth-friendly health services in cooperation with national and local partners. The institutions that provide medical and social services to adolescents can have different legal and organizational forms. Youth-friendly health services can be subdivisions of municipal health care or social protection institutions, or they can be independent organizations. A youth clinic can take up part of the premises of a different entity, or have its own premises. It is preferable that a youth-friendly health service is housed in a separate building, or at least has an independent, separate entrance to those of adult services to make sure that adolescents feel comfortable when entering.

Most youth-friendly health services are subdivisions within municipal health care or social protection institutions, like family planning and reproductive health centres, AIDS centres, maternity consulting centres, maternity hospitals, children’s polyclinics, dermatology and venereology dispensaries, narcological dispensaries, centres for social support to children and families, social rehabilitation centres and psychological support centres. Youth-friendly health services may position themselves as stationary, mobile or a combination of both. Mobile services are still not common, but they appear to be an effective instrument for serving large rural territories.

There are several official status designations listed in the Ministry of Health state register of health institutions that are used by youth-friendly health services, including “adolescent reproductive health care centre”, “department of medical and social services for adolescents” and “consultative and diagnostic centre”. In most cases, however, the youth clinic is an integral part of the host institution and does not require any special status. Naming youth-friendly health services in a “youth-friendly” manner, like “Akunamatata”, “Your world.ru” or “Yuniks”, is very popular among young clients.

Youth-friendly health services as a separate entity

The first youth clinic in the Russian Federation, the “Yuventa” reproductive health centre, was established in St Petersburg in 1993, linked to Maternity Hospital 8. At present, the centre occupies a separate building and is staffed by 160 specialists providing diagnostic, consultation, medical and preventive services to adolescents. The most frequented centre specialists are the dermatovenereologist, gynaecologist, endocrinologist and psychologist. The centre now reports nearly 180 000 visits every year.

“Yuventa” has a fully equipped clinic laboratory, which enables it to offer all necessary tests with results on the spot, a 24-hour hotline psychological service for adolescents, a wide range of additional health facilities and a web site (<http://www.teen-info.ru>) that serves as an important youth-oriented information-sharing mechanism. In addition to information materials designed by young people, adolescents can also gain access to online counselling with experts on any problems of concern to them. Review of the adolescents’ enquiries allows the clinic staff to better understand which problems related to health and behaviour are most relevant to young people.

“Yuventa” is funded from the St Petersburg city budget, which covers staff salaries and medical utilities and supports adolescents up to the age of 18 residing in St Petersburg to access services free of charge without having to provide an MMI certificate. For those over 18 and for young people living outside the city, the centre can offer paid services with prices considerably lower than the average health care prices in the city.

St Petersburg hosts more than 5 million inhabitants, of whom more than one million are young people. “Yuventa” has collaborated with local health authorities to develop a network of 21 youth-friendly counselling and referral centres in the districts of St Petersburg to make sure that this type of service is available at local community level and is easily accessible to everybody, including children and young people from the most underprivileged communities. In this way, “Yuventa” functions as a central referral centre for a number of local and first-level services spread throughout the city which provide a more basic package of services. Complementing the central service with a number of local satellites will create a comprehensive model of youth-friendly health services in a large city.

The total number of general and preventive visits to the youth clinics of St Petersburg is shown in Fig. 4.

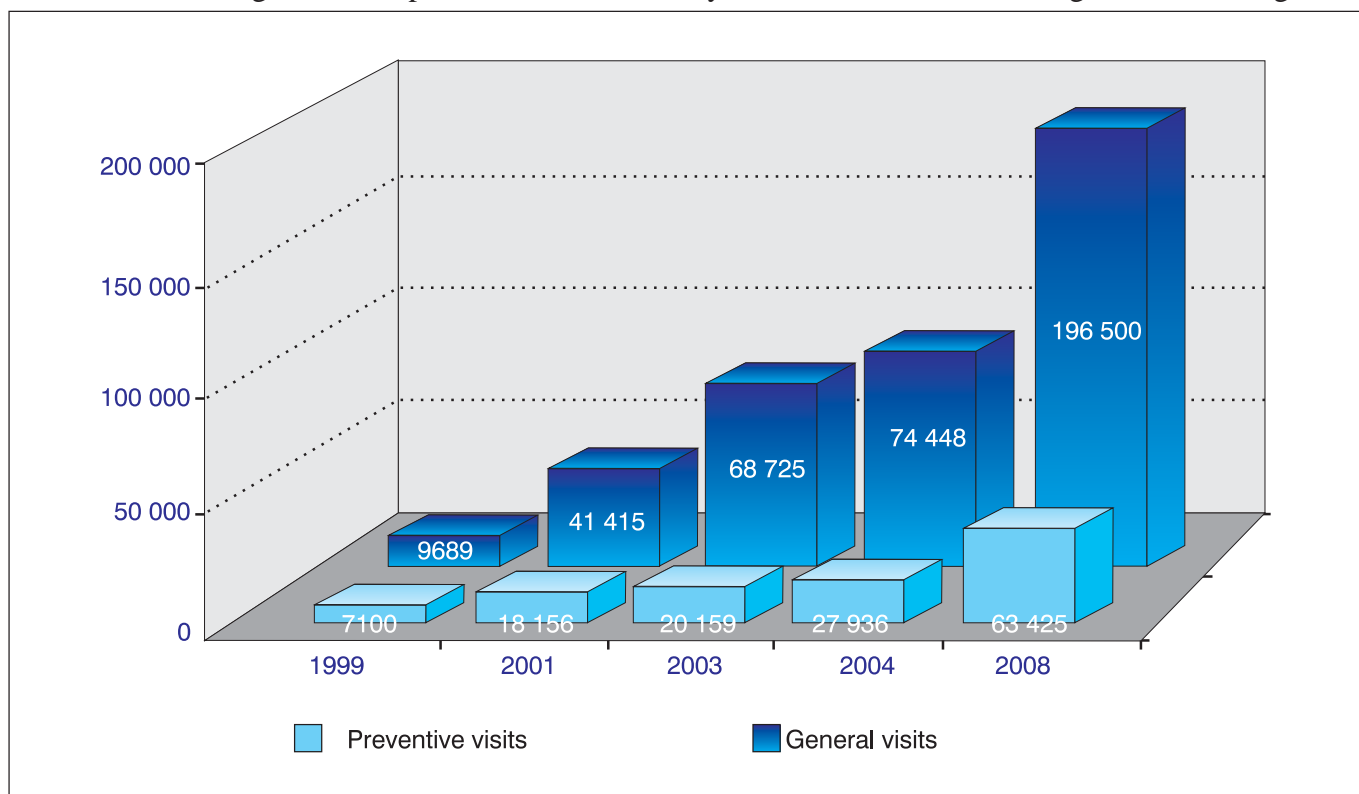


Fig. 4 General and preventive visits to the youth clinics of St Petersburg

Source: St Petersburg “Yuventa” records

Youth-friendly health services as subdivisions of health care institutions

Most existing youth-friendly health services are established as departments or subdivisions of health care institutions of different types. For instance, the youth medical centre in Tomsk (Siberia) is part of the structure of the intercollege hospital, which is the official medical institution for students of all vocational schools, colleges and universities of Tomsk. A youth-friendly health service called “Akuna matata” is a

small department within the Ulan-Ude (Buryatia Republic) Polyclinic 4, providing prevention, diagnostic, treatment and reproductive and sexual health services for the adolescent population of its catchment area. And the “Your world.ru” youth clinic is an integral part of the Tver regional centre for specialized health care services. In Volgograd region, a network of youth-friendly health services was created by incorporating reproductive health into the structure of family social support centres.

Youth-friendly health services that are subdivisions of health care institutions concentrate entirely on reproductive and sexual health and risky behaviour prevention. They are staffed by gynaecologists, urologists, psychologists and social workers, with their salaries paid by the host institution. All other health issues of clients can be addressed through referral to other specialists in the host institution, ensuring the delivery of comprehensive health care.

Given the limited financial resources of municipal health institutions, this model has proven popular, as it does not require any additional investments in staff and premises and can be implemented simply through making necessary structural adjustments within an institution.

Mobile youth-friendly health services

Mobile youth-friendly health services are considered to be one of the best ways to reach rural youth populations in remote areas that have extremely limited education and health facilities for adolescents. Three regions in the Russian Federation have positive experience of operating a mobile youth-friendly health service – Volgograd region, Altai Krai and Karelia Republic.

The mobile unit is a minibus decorated in a youth-friendly manner. It carries a team of trained medical professionals (paid by their respective health institutions) and young volunteers to rural districts that lack adolescent-oriented services to provide opportunities for the youth population to access health counselling, information and check-ups. Normally, the mobile unit visit takes several days for a given rural district. Basing themselves within an available health institution – it can be the central district hospital or perhaps an obstetric station – the team organizes a series of medical consultations and preventive activities for adolescents, their parents and relevant specialists.

Target groups

There are several target groups among the clients of existing clinics – students, adolescents who do not attend an education institution, homeless young people, those referred to the service through youth projects and medical institutions, working adolescents, wards of orphanages and shelters, children and adolescents from impoverished families, asocial and difficult-to-access groups of young people, and adolescents residing in rural areas and from other cities.

The choice of target group by a specific youth-friendly clinic is determined in the first instance by the type of host institution and its target group. As a rule, health needs of the general adolescent population are served by youth-friendly health services established within children’s polyclinics, family planning centres and consultative and diagnostic centres. The youth clinics run by AIDS centres, dermatology and venereology dispensaries, narcological dispensaries and social rehabilitation centres mainly cover socially disadvantaged groups of adolescents and young people.

It is quite natural that more HIV-positive and substance-dependent young people will be among the clients of a clinic created within a centre for prevention of AIDS that also includes a needle-exchange station for injecting drug users (Barnaul, Biisk).

If there is more than one youth-friendly health service operating in a city, the clinics often find responsibilities divided between them – one will take the “underprivileged” young people among its clients, while the other may cater for the more “organized” youth (those who are college or university students, for instance). This

happens quite naturally – the clinics do not make this division one of their goals and do not aim to limit the circle of their clients.

The Tomsk youth medical centre, located in the building of the intercollege hospital, was initially designed to serve the general youth population, but its location made it a “student” centre. While the main target audience of the centre is adolescents and young people who are considered to be “privileged” (students), the clients of the Tomsk “Our clinic”, which is situated in a socially disadvantaged area, are “underprivileged” or vulnerable adolescents – drug-users, teenagers involved in the sex industry, homeless and street children, rural youth and teenagers from low-income families. The clinic is housed in its own building and, unlike other clinics, the atmosphere is very non-medical (even the doctors do not wear the usual medical uniforms); this surely helps to make the adolescents feel safe and comfortable.

Tomsk “Our clinic” is one of the best examples of providing services for adolescents who are most at risk. Established in 2002 as a joint initiative of the Tomsk regional AIDS centre and the “Tomsk-anti-AIDS” NGO, “Our clinic” provides young clients with counselling, diagnostic, medical and psychological assistance and rehabilitation services. Adolescents and young people can be examined and treated for STIs and HIV/AIDS, with consultations provided by highly skilled staff (psychologists, venereologists, gynaecologists and social workers). The young people can also share their problems with their peers who work as trained volunteers.

As one of the main features that distinguishes youth-friendly health services from traditional health care institutions is prevention, another target group of the Russian Federation’s youth-friendly health services is parents and other adults in an adolescent’s surroundings. A set of activities including outreach, information sessions, parents’ meetings and counselling is organized to make sure that the adults know where an adolescent can receive the necessary help and information and understand the importance and relevance of youth-friendly health services’ work.

Working with male adolescents

The number of adolescent males attending youth clinics is significantly lower than that for adolescent females. Males comprise at best only 20% of clinic attendees, with an average rate of less than 10%. Usually, boys seek help for a suspected STI; they rarely come for a routine examination or for contraception counselling.

Reasons for boys’ low attendance include the fact that the original design of youth-friendly health services was as “girls” reproductive health services, the lack of professionals trained in providing consultative, medical and diagnostic services to male adolescents, and the specific characteristics of boys’ and young men’s health behaviours (rare voluntary visits to the clinic, presenting for examination and treatment in medical institutions only when pronounced clinical symptoms develop, a tendency to consult friends for advice on STIs and other diseases, and the desire for anonymous treatment in private medical institutions). This emphasizes the fact that more preventive activity should be aimed at male adolescents.

Youth participation

Participation of young people is a critical component in the prevention and health promotion activities of youth clinics, but its extent varies with the organizational structure (that is, whether the peer participation is within the youth-friendly health service or is provided through close collaboration with an NGO or government organization partner). It is very important to take young people’s views into account when setting up a youth-friendly health service to ensure that adolescents feel comfortable coming to these institutions for help. And it is especially important to receive regular feedback from the clinic’s clients to improve aspects of activity and to be sure that the services provided suit adolescents’ needs and demands.

There are different ways in which young people can participate in organizing a youth-friendly health service.

During the preparatory period, adolescents can participate in focus groups and express their preferences and demands for the clinic. They can also carry out some organizational tasks: for example, before the opening of “Our clinic” in Tomsk, staff held a focus group with young people that helped the specialists to understand what scares young people away from “standard” medical services. As a result, the information stand at the clinic does not say anything about the specialization of the doctors – it just provides pictures, names and information about what problems the doctors can address.

Young people also actively participated in the organization of the Tomsk youth medical centre. Colleges and school students wrote essays on the topic: “What the centre should look like”. A special commission consisting of college students – future designers, psychologists and sociologists – supervised the design and redecoration of the premises. These young people conducted market research, developed the plan for the clinic and chose the furniture and colour schemes.

Teams of volunteers trained by specialists in peer-to-peer approaches who have the knowledge and skills necessary to work with their peers are extremely effective in organizing peer-to-peer sessions and youth health-oriented events in schools, youth clubs and other youth settings, as well as in distributing information about youth-friendly health services.

There are many different ways of advertising youth-friendly health services, including the mass media and through printed materials (booklets, posters, etc.), but the most effective way is when adolescents spread the word themselves. Analysis of sources of information about youth-friendly health services carried out as part of a study (12) showed that the greatest proportion of respondents (43%) found out about the clinic from their peers. Another significant source of information (27.2%) turned out to be medical professionals.

Locations and performance

From 2000 to 2009, 117 youth-friendly health service facilities were established in 28 of the Russian Federation’s 83 regions. They provide reproductive and sexual health services to approximately 1.5 million adolescents and young people. Through the capacity-building of youth-friendly service facilities, around 1000 specialists (doctors, social workers and psychologists) have gained skills on how to organize and implement youth-friendly services.

The effectiveness of the youth-friendly health service model is demonstrated through the increasing number of regions that are ready to invest their own resources in establishing new youth-friendly health services, particularly in light of decentralization of health services to the regions (Fig. 5).

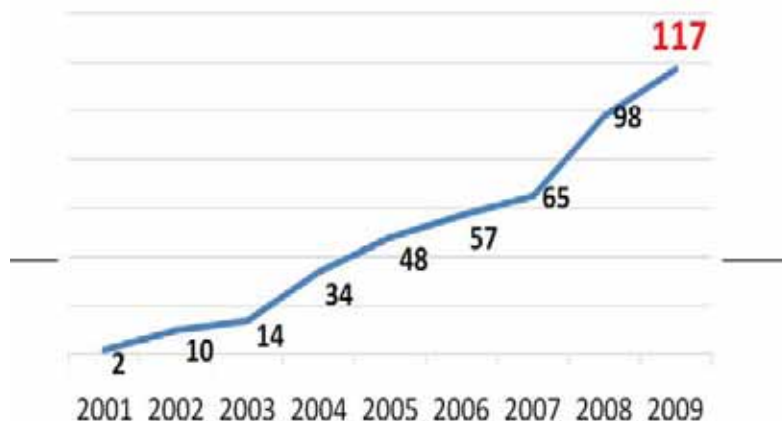


Fig. 5 Number of youth-friendly health services in the Russian Federation by year

Development of youth-friendly health services in Magnitogorsk is a good example of this situation. Having learned about the approach through a conference, the city administration’s health committee decided to establish a separate youth-friendly health services office. Prior to this, the adolescent health unit was housed

in a building alongside other health units. The administration's decision gave them, from the city budget, a separate building which was fully equipped and refurbished. The administration fully supported the youth-friendly health services idea. UNICEF's contribution consisted of organizing an orientation meeting with the Magnitogorsk administration and a training session for 100 staff and young volunteers. Within the first 12 months, Magnitogorsk youth-friendly health service provided services for 15 000 adolescents.

An example of the low cost and high impact of UNICEF's dissemination of the model can be seen in the experience of a dermatology and venereal disease dispensary in Tver (now renamed as a centre for specialized health care services). Based on participation in a Ministry of Health/UNICEF-supported national conference, the dispensary decided to establish a youth-friendly unit. UNICEF experts were requested to provide modest capacity-building and structural design support. Within approximately three months, this centre had a fully functioning youth-friendly health services unit. The centre provided services for 3000 adolescents in its first six weeks.

The results of the youth-friendly health services desk survey conducted in 2008 with participation from 12 units located in 10 territories supported by (or established due to) the UNICEF project demonstrate the following:

- UNICEF project support is provided to initiate the establishment of youth-friendly health services and lasts for no longer than one year, but none of the units established as a result of the project has stopped functioning, with a longest "lifetime" of nine years (not counting the pioneers like "Yuventa" and "Yuventus"); this proves the sustainability of youth-friendly health services;
- the average number of personnel is nine people per clinic, with an average coverage of 20 000 adolescents in the catchment area;
- on average, the number of primary visits of adolescent clients increased by 5.5 times from 2000 to 2008, with all clinics reporting an increase;
- although there was a small decrease in the number of abortions among adolescents (ranging from 4.5% to 33%), the number of repeat abortions among clients of the clinics decreased by 78.2% on average;
- the number of consultations about contraception doubled, on average; and
- preventive activities of surveyed units proved to be well developed, with a 12.7 times average increase in the number of "healthy clients" seeking not diagnosis and treatment, but information and advice.

National capacity building

UNICEF's work has had a catalytic effect over the past decade, assisting the Ministry of Health in disseminating the youth-friendly service model to the Russian Federation's regions and by strengthening local knowledge hubs and supporting grassroots efforts to apply the youth-friendly approach.

To ensure scaling-up of the model throughout regions, a training and methodological centre was established within the St Petersburg Medical Academy of Postgraduate Studies (MAPS) Adolescent Health Department in 2006. Partners from the ministry and the St Petersburg "Yuventa", the oldest and largest youth-friendly unit in the country, play a critical role in building the national capacity of health and social service providers working with adolescents through advocating for youth-friendly health services to regional administrations, providing training for specialists and developing training and methodological materials.

A review of existing medical training programmes revealed the lack of a course that incorporates both youth-friendly approach criteria and state standards on professional retraining. As a result, a 72-hour training course, "Medical and social services for adolescents" and a 72-hour training course on "Adolescent sexuality" were developed by MAPS Adolescent Medicine Department specialists, with approval by the MAPS methodological council. These courses are in high demand and are currently available (at the expense of local health authorities) to health care professionals and non-medical staff of youth-friendly services (social workers and psychologists) from all regions of the Russian Federation.

The training and methodological centre is serving as a main UNICEF partner in shaping, orienting and

developing regional initiatives on youth-friendly health services. The centre's close cooperation with the two other UNICEF key partners in the project – “Yuventa” and the youth NGO “Look into the future” – proved to be extremely fruitful and has resulted in wide dissemination of the model into about 30 territories. Its experts are widely recognized as the best source of information and methodological support for the majority of regions taking part in youth-friendly health services work.

In 2007, MAPS experts helped to link the Russian Federation and European adolescent health communities. Through their participation in Lausanne University's EuTeach summer school on adolescent medicine in 2004 and 2005 (13) and other working contacts, colleagues raised interest among European specialists about the youth-friendly work in St Petersburg and the Russian Federation and also highlighted the need for a Russian Federation-based EuTeach summer school programme on adolescent health for specialists.

Access to the EuTeach resources on adolescent health has been limited for the majority of Russian Federation and Commonwealth of Independent States (CIS) specialists due to the constraints of high costs and the English language requirement. Following a number of working contacts with Lausanne University's EuTeach group, it was agreed to launch a Russian-language branch of EuTeach based on the expertise of MAPS. Through this work, Russian Federation experts have taken a lead in building opportunities for CIS colleagues and other Russian-speaking specialists to access technical expertise on adolescent health approaches. The first Russian Federation EuTeach summer school on adolescent health took place in St Petersburg in May 2008 for 28 specialists from the Russian Federation, Ukraine, Kazakhstan, Kyrgyzstan and Uzbekistan. The second was conducted in May 2009, with active participation from 29 specialists from the Russian Federation, Ukraine, Belarus, the Republic of Moldova, Kazakhstan, Kyrgyzstan and Uzbekistan.

Complementing the expansion of youth-friendly health services in the regions, UNICEF has supported the development of new resources that promote healthy lifestyles for adolescents and young people. An example is the “Discovery” programme, which provides a more “neutral” perspective on healthy lifestyles and is targeted at developing and strengthening young people's capacities to resist behavioural risks and to favour healthy lifestyles. It promotes issues such as personal values and team building, using outdoor education approaches. Another training programme developed specifically for youth-friendly health services staff is the first Russian Federation programme manual on how to conduct dialogues with adolescent boys about reproductive and sexual health issues. There is also a training set of four manuals on peer-to-peer approaches in prevention programmes.

To further build capacity of service providers working in the area of adolescent health, the adolescent health web site for service providers – *adolesmed.ru* – was developed and launched in 2008 (Fig. 6). This is the first Russian Federation methodological web resource that focuses on issues around adolescent health, including a special section on youth-friendly services. Web site resources include information such as an inventory of international and Russian Federation training and “best practice” examples, a user-friendly methodological package for practitioners based on the WHO methodology and tools for measuring the quality and extent of youth-friendly health services.



Fig. 6 adolesmed.ru

The youth-friendly health services model has been documented through a manual that is designed to meet the practical needs of service providers and to provide data on existing best practices in the Russian Federation and abroad. In addition, methodological documents on youth-friendly health services have been developed. These include:

- guidelines on youth-friendly health services (published in April 2006) that are designed for health service providers and managers dealing with medical and social services for adolescents and young people; the guidance contains international standards and criteria of adolescent health care provision and principles of youth-friendly health services' functioning in the Russian Federation, a detailed procedure for achieving "youth-friendly clinic" status, and the personnel training programme;
- the youth-friendly health services quality and coverage measurement package; and
- the youth-friendly health services advocacy materials package.

Evaluation

Various assessments and surveys conducted in the period 2001–2006 have confirmed the project's effectiveness. Among the most important and informative are:

- the expert assessment of youth clinics in the west Siberian region (2003/2004, in cooperation with WHO headquarters) (12);
- a study of the coverage of St Petersburg adolescents and youth by services of reproductive health care institutions and facilities (13);
- a study of knowledge, attitudes and practices in the area of reproductive health among St Petersburg adolescents (14); and
- an external evaluation of the youth-friendly health services programme in the Russian Federation (November 2006), which is being used as evidence to support scaling-up the model and advocacy at regional and federal levels for official support.

To ensure sustainability and promote further development of youth-friendly health services in the Russian Federation regions, the Ministry of Health, with UNICEF support, has initiated a process aimed at improving the quality of existing services provided for adolescents and young people through youth-friendly health services accreditation. A clinic has to demonstrate its compliance with the basic principles and criteria of youth-friendly health services through self-assessment, expert assessment, learning by experience and other methods. The service can use the process and its instruments to review and assess its current status to make necessary improvements and adjustments that lead to increased quality of youth-friendly health services and make them more attractive to adolescents and young people.

Conclusions

The experience of developing youth-friendly health services in the Russian Federation has proven that adolescents and young people in all regions of the country need medical, social and psychological services that address issues specific to their age. Timely provision of these services from qualified professionals is a major factor contributing to the protection of their health. There is a clear and confirmed demand for youth-friendly health services in the Russian Federation and they should be further developed.

Governance

The Ministry of Health of the Russian Federation has recognized the value of youth-friendly approaches in delivering age-appropriate services and has endorsed all the developed youth-friendly health services guidelines. In general, the Russian Federation is incorporating youth-friendly health services into the system of state health care, ensuring their sustainability.

Through UNICEF's initiative with Russian Federation partners, a tested and documented youth-friendly service model has been established. The model has proven to be cost-effective and flexible. It can easily be integrated into existing medical service infrastructures and participating medical services are able to become self-financing, either from the beginning or shortly after. No special cost-effectiveness studies have been conducted, but local health authorities' feedback on investments needed to launch youth-friendly health services proves that the model is efficient and does not require massive financial investments, which increases its attractiveness to administrations.

The combination of budget and MMI financial sources provides flexibility in covering "additional" services, such as psychological and social support. The most expensive part, relating to staff orientation and training, has so far been covered by UNICEF. Further strengthening of national youth-friendly health services expert capacity (including training and methodological hubs in different regions of the country) is considered the most effective way to fill the existing personnel training gap.

The majority of youth-friendly health services in the Russian Federation belong to health care or social protection sectors. In both cases, regulations allow clinics to be granted official status. Presently, the most active development of youth-friendly health services is occurring in the health care sector. Whatever its sector location, however, effective youth-friendly health services operation requires the building of cross-sectoral cooperation, at a minimum involving health care, social service, education and youth affairs authorities. Streamlined mechanisms for cross-sector interaction that include dissemination of experiences and best practices should become another important priority for youth-friendly health services development in the Russian Federation.

When a youth-friendly health service is launched, it should pay special attention to building relationships with school administrations and the parents of potential clients. It is also important to begin dialogue with church representatives. Experience proves that dialogue is possible despite major points of disagreement. Conservative politicians and public organizations could also pose a considerable risk to youth-friendly health services. The most effective way to counter this risk is to be prepared to give a sound, substantiated and professional response to criticism and attacks. This response is most effective when it presents a common professional position established within the medical community.

Service delivery

The concept of youth-friendly health services, as it has been formulated and implemented by the Ministry of Health and partners in cooperation with UNICEF Russian Federation, includes not only medical aspects of assistance required by, and provided to, adolescents and young people, but also the whole range of social, psychological, legal, referral, rehabilitation and other services that young people may need at various periods of their lives, especially when they happen to find themselves in difficult circumstances.

Available options are that either the organization provides all the aforementioned services (which is not always possible), or refers the client to other organizations/agencies that can provide them. In either case, youth-friendly health services should be integrated into local networks of government agencies and other organizations working with the same target group and/or in the same field.

The Russian Federation experience shows that a viable way to establish a youth-friendly health service is to launch it as an integral part of a health care or social service institution. Launching a youth-friendly health service as a separate organization is seldom possible at present; it requires very substantial financial and administrative investment that is not readily available at municipal level. It has been easier to launch a service as a subdivision within an organization than to give it the status of a separate structural division. However, a youth-friendly health service is more sustainable when set up as a separate division with its own staff and budget, as the service is not dependent on the host institution's policy fluctuations and financial sustainability.

Youth-friendly health services activities should include constant monitoring of target group needs to ensure services are adjusted as necessary and to offer follow-up support to clients and/or provision of post-rehabilitation services such as support groups and social events.

On the whole, the youth-friendly health services existing today meet clients' expectations. The results of one study (12) show that 80.8% of participating clients received the help they were looking for at the clinic, and 71.4% got the answers to all their questions after visiting the clinic. The majority of services are territorially close to where adolescents and young people live and learn; the survey results show that most clients do not spend more than 30 minutes in getting to the clinic. Almost all the services required can be obtained in the clinic's premises, or a well-established system for referring clients to other institutions will exist.

Human resources

The "friendliness" of services (easy access, warm-hearted attitude, trust and voluntary participation) is their principal feature. Friendliness is the major quality component that makes them so popular with the target group, but it doesn't come naturally and is not directly tied to the personal qualities of the staff (although, obviously, not every individual would be able to work with adolescents in a friendly manner).

All the professionals working in a youth-friendly health service have to have special training. They have to learn about adolescent psychology and about the specifics of providing services for this age group, as well as to master effective communication skills.

The set of specialists depends on the orientation and capacity of the clinic, but the standard minimum set of specialists includes a gynaecologist, a urologist (andrologist), a dermatovenereologist and a psychologist. The staff of some youth-friendly health services also includes social workers who help adolescents overcome difficult situations and education specialists leading prevention activities.

Careful selection of personnel and appropriate training, in addition to compliance with a number of specific requirements, technologies and organizational procedures, are necessary to ensure the friendliness of a clinic's services. A system of professional development for personnel, the use of external consultants and regular review of operations could contribute to maintaining the high quality of services and ensuring their friendliness.

The Medical Academy of Postgraduate Studies in St Petersburg serves as a centre of scientific and methodological expertise and has played a major role in the development of youth-friendly health services in the Russian Federation. Support and further development of this expertise should be made one of the priorities for future development.

Youth-friendly health services bring benefits not only to adolescents and young people. Their advantages

are felt by many. Adolescents benefit from having a real channel to receive medical and psychological help and health-preserving information and, in general, by an easier passage through their coming-of-age period. Parents can rest assured about the health of their children, knowing that they will get all the necessary assistance and information they need from qualified professionals. Administrators (in health care, education and social services for the young) can arrange for an effective (that is, effort- and resource-saving) service that is focused on both treatment and prevention of socially significant diseases.

Adolescents' attendance at youth-friendly services and the wide dissemination of the model among regions reflect the potential success of this model if adopted nationwide. Accessible youth-friendly health services throughout the Russian Federation could contribute to adolescents and young people having better reproductive health and healthier lifestyles, as well as reducing the risks of HIV and STIs.

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References

1. *Data and analysis on the lives of children in CEE/CIS and Baltic states. TRANSMONEE 2007 Features.* Florence, UNICEF Innocenti Research Centre, 2007.
2. The Russian Federation population estimation as of January 2009 and on average for 2008 [web site]. Moscow, Federal State Statistical Service, 1999–2009 (http://www.gks.ru/free_doc/2009/demo/popul09.htm, accessed 18 August 2009).
3. *The European health report 2005. Public health action for healthier children and populations.* Copenhagen, WHO Regional Office for Europe, 2005 (<http://www.euro.who.int/ehr2005>, accessed 18 August 2009).
4. Ovcharova LN, Pishniak AI, Popova DO. *Families, fertility and child poverty: impact of the latest maternity and child support measures on the birth rate and living standards of families with children in the Russian Federation.* Moscow, UNICEF, 2007.
5. *Juvenile technologies. Practical instructions for implementing geographic models for rehabilitation centres for minors in risk groups.* Moscow, No to Alcohol and Narcotics Addiction, 2002.
6. *Situation analysis of children in the Russian Federation. Prepared with the support of the Institute for Urban Economics.* Moscow, UNICEF Russian Federation, 2007.
7. *Boys' attitudes to risky behaviours.* St Petersburg, Medical Academy of Postgraduate Studies, 2006.
8. Oxford Analytica's Daily Brief Services. RUSSIA: narcotics present domestic and global threats [web site]. Oxford, Oxford Analytica, 2009 (<http://www.oxan.com/display.asp>, accessed 10 July 2009).
9. *Adolescent mortality in the Russian Federation. Survey.* Moscow, Scientific Center of Children's Health of the Russian Academy of Medical Sciences, 2008.
10. Data presented by the Ministry of Health and Social Development. *The Youth-friendly Clinics Conference, St Petersburg, June 2006.*
11. European health for all database [online database]. Copenhagen, WHO Regional Office for Europe, 2004 (<http://www.euro.who.int/hfad>, accessed 10 July 2009).
12. *Achievements of the International Ado Girls project in the Russian Federation. Expert assessment of youth clinic in the west Siberian region.* Moscow, UNICEF Russian Federation, 2003.
13. European Training in Effective Adolescent Care and Health Programme [web site]. Lausanne, University of Lausanne, 2007 (<http://www.euteach.com>, accessed 10 July 2009).
14. *Coverage of St Petersburg adolescents and youth by services of reproductive healthcare institutions and facilities.* St Petersburg, Medical Academy of Postgraduate Studies, 2006.
15. *Study of knowledge, attitudes, and practices in the area of reproductive health among St Petersburg adolescents.* St Petersburg, Medical Academy of Postgraduate Studies, 2006.

Sweden: promoting youth health through promoting the Convention on the Rights of the Child

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Executive summary

The case study from Sweden illustrates how supporting the application of the United Nations *Convention on the Rights of the Child* promotes the health of young people. The Children's Ombudsman is charged with representing the rights and interests of children and young people against the background of Sweden's commitments under the convention.

The case study provides examples of how this can be achieved. It deals with the theoretical implications of the activities involved and the impact they have on society and on children's and young people's rights to "connect" with their communities. The discussion focuses on the connection of this to young people's health by outlining the demographic characteristics of young people in Sweden and describing the health services available to them, their health issues and health-related behaviours, and the policy environment for health promotion.

Background

Demographic characteristics of the young population of Sweden

Sweden is a country that is about 2000 km long but which has only 9 300 000 inhabitants. Most live in the southern parts of the country, which leaves the most northerly part sparsely populated.

The three major cities are Stockholm, Goteborg and Malmo, which have approximately 3 million inhabitants (including those who live in suburbs). In 2006, 36% of all children lived in these cities. The majority of young people live with both biological parents.

There were 1.2 million young people in the age range 10–19 years in Sweden in 2008. Of these, approximately 140 000 were born abroad; an equal number were born in Sweden but had parents who were born abroad. This means that the immigrant population accounts for up to 20% of all young people in the country. The majority of these people come from non-western countries, mainly Iraq and Somalia, and also from Serbia, Bosnia and Herzegovina, the former Yugoslav Republic of Macedonia, Croatia and Slovenia. Around 1000 minors come alone to the country each year. Young people from western European countries, mainly from other northern countries, also live in Sweden, but probably number fewer than 20 000.

Sweden receives more immigrants than any other European nation, which has created some social and political problems. The immigrants bring with them cultures, family values and religions that are very different from the northern Protestant and western European individualist traditions of the indigenous population. Despite the best intentions, the country has experienced great difficulties in managing immigrant groups and integrating them into society. Many young immigrant families now live in suburbs of the three major cities in which very few people speak Swedish. The unemployment rate is high among parents and young people of immigrant families, and many of the young people are, and will remain, marginalized through lack of education and language proficiency. This is recognized as a major problem for the country.

Education

School is obligatory up to the age of 16, but most young people continue for another three years. All children who stay in school have a school allowance paid to their parents; this allowance is paid to the students themselves after the age of 18. Schools provide free lunches; generally, these are of a very high standard and offer a variety of options, but they are not always popular with students.

Recently-arrived immigrant young people are placed in special classes for evaluation of skills and introduction to the Swedish language. They are then streamlined into age-appropriate classes according to their academic skills and language proficiency as soon as possible, usually within one school year.

The objective of secondary school is to provide everybody with the skills to allow them to enter university, but about 11% of all students even fail to make elementary school due to lack of knowledge in one, two or all three of the key subjects – Swedish language, English language and mathematics. These students are referred to remedial classes (called “individual programmes”) in which municipalities are required to support them to gain the requisite skills and knowledge for entry to secondary school, if possible. Children who succeed in the remedial classes can then move on to secondary school.

Around 11% fail to gain proficiency for academic studies after secondary school. Local communities have a responsibility to provide those under 20 who do not go to school or work with some sort of follow-up, offering them jobs or apprenticeships, but many are offered no such opportunities.

The guiding principle for those with physical disabilities is integration into ordinary schools and classes. This could mean provision of classroom assistants and assistants to help them with personal care. Special centres of excellence have been established to enable teachers to support students with, for example, severe sight, hearing or motor disabilities.

Availability of medical services and youth-friendly health services

Medical care is free for those under 20 years in most Swedish regions. Young people can attend any medical service unit without their parents’ permission or knowledge. Medicines to the value of 1800 SKr (about €170) per year have to be paid for all children below 20 years in the same family, and are free after this. Preventive services, including school health and sexual reproductive health services, are free. Vaccinations are administered through school health services.

Only 23% of young people say that they know where to go if they are dissatisfied with the treatment they are given, and most have no knowledge of where to register their complaint.

All communities offer contraceptive services. Youth-friendly health services exist in so-called “youth centres” in 225 of the 290 municipalities. To qualify as a “certified” youth health centre, according to the Association for Youth Centres, there has to be a midwife, a social worker and/or a psychologist and a part-time physician for every 3500 young people. The upper age limit is usually 23 years. The core competence of the youth health centres is in health promotion and sexual reproductive health problems, but they also offer psychological support and counselling, especially in the bigger centres.

The focus for youth health centres is traditionally on women. Only 15% of attendees are male, and many of them attend as companions of women who have a sexually transmitted infection (STI). The goal of promoting gender equality is therefore not being met.

Some centres, especially in urban areas, are able to attract more male visitors by offering “men-only” evenings and having a physician specializing in andrology or urology on the staff. These centres report males as being an “underserved population” with long-standing medical needs and worries. Young men have also been neglected in relation to abortion, reporting that they worry about their girlfriend’s health and feel left-out of the decision process (1).

School health services

The school health service has a long tradition in Sweden. The first school health physician was employed in 1830 in a private boys’ school in Stockholm. Services were then developed all over Sweden. Treatment

of illnesses was the focus during the first 100 years, with disease prevention added in 1944, first with vaccinations for tuberculosis, diphtheria and tetanus, then with screening for hearing and vision disabilities and various orthopaedic problems.

Sweden went through serious economic crises in the early 1990s. As a consequence, important prevention and health promotion systems suffered from reduced budgets. School class sizes became bigger, facilities for students with learning problems decreased, and more students with disabilities were streamlined into normal classes without extra help.

School health services ceased to be a national responsibility in 1991 and were instead devolved to the municipalities. They generally suffered as a result, with positions for psychologists and social workers reduced and higher per capita ratios of students to nurse practitioners and physicians. Many were localized in a central unit, not in the schools (as was the case previously). The therapeutic focus was on individual services for students and families rather than the previous concentration on promoting health. These trends have continued in the 2000s.

School health services now play an important role as a first line of support for students by responding to their questions about health, treating minor illnesses and referring to appropriate services. Treatment of diseases is not offered in the schools. School health services include a nurse practitioner, a consulting physician and very often a social worker and a psychologist, at least working part time. The nurse performs traditional health screening and vaccination programmes, and the team has an important role in promoting a healthy school environment by controlling noise, preventing accidents and addressing other hazards. A healthy environment for mental health and well-being is promoted by working with others in the school to identify, treat and prevent bullying, violence and sexual harassment.

School health services also aim to erase obstacles for students with functional disabilities and chronic illnesses which hamper their school performance by forming teams with the school headmaster and special-needs assistants. These teams meet with students and parents when necessary to discuss problems and explore what can be done for each individual student.

Health education is part of the national curriculum, but the quality of, and interest in, delivery varies. Students from the age of about 10 years have annual individual health promotion and counselling sessions with the school nurse practitioner, an opportunity that most nurses take very seriously.

Child school vaccination programmes are efficient and include seven diseases (polio, diphtheria, tetanus, measles, mumps, rubella and *Haemophilus influenzae*). Ninety-six per cent of children born in 2004 had completed all those vaccinations by the age of two years. School vaccination programmes continue the infant vaccination programmes and provide booster doses as recommended; they also offer complete programmes for those who have not received vaccinations before school. Bacille Calmette-Guérin (BCG) and hepatitis B vaccinations are offered to selected groups. *Pneumococci* vaccines and human papillomavirus (HPV) vaccine for girls will be offered in 2010.

The Children's Ombudsman investigated the school situation in 2002, finding that 84% of girls and 81% of boys were satisfied with their teachers. More than half the students had seen the school health nurse practitioner at least once during the preceding year and 19% had done so on more than three occasions. Only 4%, however, reported that the nurse attended the school on a daily basis, and 64% said they wanted the nurse in their school more often. Twenty-five per cent had no social worker and 30% no psychologist in their schools (2).

Health, health-related behaviours and policy environment for health promotion

Health promotion strategies for young people in Sweden

Sweden has a long tradition of health promotion strategies for children and young people within the public

health sector and school health services.

In the 1970s, the public was alarmed by reports of young people's unhealthy behaviours, with increasing substance use (alcohol, tobacco and illegal drugs) and rising abortion rates for young women. A new abortion law in 1975 acknowledged women's rights to free abortion before week 12 of the pregnancy (this was later to be extended to 18–20 weeks). Youth health centres were launched all over the country to improve sexual health and to prevent abortion being the contraceptive method of choice for young women.

School education objectives were changed in 1974 to include health promotion and discussion of life values. Activities in and outside school, such as peer counselling to prevent drug use and camps in which early teens could discuss life values, were initiated. Attempts were also made to provide young people with meaningful after-school activities, with many nongovernmental organizations (NGOs) involved.

This broad attack on unhealthy lifestyles was very effective. Multi-agency work on health issues has become standard in many municipalities. Adoption of unhealthy lifestyles by young people has decreased significantly over the past 15–20 years, but substance misuse and, in particular, mental health problems have been on the rise over the same time period (3).

Other public health actions taken in Sweden concern prevention of traffic accidents, with use of safety helmets when driving mopeds and motorcycles compulsory, a legal age for driving of 18 (and only after demanding tests), and low tolerance of alcohol when driving (below 0.2 parts per thousand).

Sexual behaviours

Sex education and family life skills have been compulsory parts of the school curriculum since 1974. Generally, parents accept that their children are sexually active from mid-adolescence, but the sexual habits of young people have been changing during the last decade. The majority of young people have had their first intercourse by age 17, and it has become more common to have sex on the first date (37% of 16–17-year-old girls reported this in 2007, compared to 14% in 2002). Young people have also reported more sexual partners during the last decade.

Abortion rates vary over the country, but the national average in 2008 was 24 abortions per 1000 women under 20 years of age. Most abortions (76%) are carried out before the end of week 9 of pregnancy, and medical abortions dominate (83%). Ninety-six per cent of all pregnancies among 15–17-year-olds end in abortions, and 79% for 18–19-year-olds.

Three quarters of girls and one third of boys approve of homosexual relationships, and an increasing number experiment with same-sex activities during adolescence (4).

Condoms are freely available in schools and youth health centres, and contraceptive pills are generally subsidized, as is the morning-after pill for those under 20 (under 23 in some regions). Health professionals are concerned that despite this, abortion rates are not decreasing, and Chlamydia infection rates are rising.

Chlamydia infections have tripled in the last decade. The age group 15–29 years accounted for 88% of Chlamydia infections diagnosed in 2007, with the greatest increase among 15–19-year-old females (60% higher in 2007 than in 1994). More females than males are diagnosed, possibly because males have less-pronounced symptoms.

HIV infections in young people are rare, and in most cases are acquired congenitally.

The common explanation currently offered for increasing STI rates is that asking a partner to use a condom implies that he or she has an infection, which might be difficult for some young people to broach. There is also an inaccurate perception among young people that with new drugs available, HIV is no longer a problem and that STIs do not pose a serious threat to health.

Alcohol , tobacco and substance use

Alcohol is considered a serious health hazard in Sweden and its distribution and sale are heavily controlled by the government. The high price of alcohol products represents a conscious strategy to control consumption levels. Alcohol is sold only in special centres, “Systembolaget”, as part of the general alcohol abuse prevention strategy. These provide excellent service and have a wide range of alcoholic products available, which makes the system acceptable to the majority of the population.

The age limit for purchasing alcoholic products is 20 years, with salespersons being encouraged to decline the sale when in doubt. Young people in most communities nevertheless get hold of alcohol easily through illegal sales.

Heavy drinking, binge drinking and regular drinking at young ages (including among girls) are serious short- and long-term health hazards. The biological dangers of heavy drinking during adolescence have probably been underestimated. Parents are often not aware of their child’s drinking or do not see it as a problem, further supporting the drinking culture.

Interestingly, and for no obvious reason, heavy drinking among 15-year-olds has actually decreased in some areas in the last few years; it is simply no longer considered “cool” to get drunk. In 1975, 90% of 15-year-old boys and girls had used alcohol in their lives; in 1989, the figure was 75%, and in 2008, it was 65%. The total consumption of alcohol for both genders increased from 1980 to 2000, however, mainly through the consumption of hard liquor and strong beer, but since then consumption has decreased somewhat for boys and now equals that of girls, whose consumption continues to increase.

In 2005, 80% of boys and girls aged 15 years had been drunk at some point in their lives, but few below the age of 13 had been so. In 2008, 9% of boys and 12% of girls had accidents or were hurt when using alcohol, and 3% had had to visit an emergency room. Six per cent of boys and 8% of girls had unwanted sex while under the influence of alcohol, but the most frequently reported problem was getting into quarrels (16% and 26% respectively). Four per cent of boys and 7% of girls admitted that drinking had caused school performance problems (3).

Use of tobacco is also controlled by high prices, age restrictions (seldom enforced) and by prohibition of smoking in public buildings, restaurants, cafes and similar places. As with alcohol, illegal sales are common. More young women than men smoke, and those from lower socioeconomic backgrounds smoke more. However, if the figures on use of oral snuff and cigarette smoking among boys are combined (use of oral snuff is basically a boy’s habit), the difference in tobacco use between genders disappears. Overall use reduced somewhat during the 2000s (3).

Alcohol use and binge drinking may be acceptable in Sweden, but use of illegal drugs, including marijuana, is definitely not. It is illegal simply to possess marijuana. Culturally, drug use is considered unacceptable in Sweden, meaning the country has low rates of substance use in comparison with most western countries. The lowest levels were recorded in 1989, when only 3% of 15-year-old students admitted to having tried marijuana. In 2008, 7% of boys and 5% of girls of that age had tried it. Students two years older reported increased rates of experimentation, with 17% of male students and 15% of female students having tried marijuana (3).

Physical health of young people

The physical health of young people in Sweden is generally considered good. The rate of chronic conditions is hard to estimate due to lack of strict definitions, but serious disability can be estimated at around 10%.

The mortality rate for young people is low, with 300 males and 120 females in the age group 16–24 years dying annually. According to figures from the National Board of Health and Welfare, accidents account for

40% of deaths among males and 27% among females. Suicides account for 25%.

Height and weight are regularly checked through school health services and overweight and obesity discussed. There is general awareness and concern over the obesity epidemic in Sweden. Schools and parents have taken several actions, often together, which include no sweet snacks in school, more salad options at lunch, and more physical activity, including encouragement to walk to school (“the walking school bus”) and similar activities. Currently, there does not seem to be any increase in the proportion of overweight and obese young people in the country.

Mental health and well-being among young people

Mental health problems and stress-related and psychosomatic disorders have increased in recent years, particularly among girls.

According to reports from school health services and health care providers, depression and stress disorders, including sleep disturbances and eating disorders, are increasing, especially among older adolescents. National data show that the number of young people aged 15–24 years hospitalized for mental health problems increased between 1988 and 2003, despite fewer hospital beds being available.

The reasons for these increases in psychological distress are not well understood, and a questionnaire was distributed to representative samples throughout the country in 2009 to attempt to gather solid data on psychological health. Reductions in services for young people may have contributed to the present state, particularly the lack of school nurses available on a daily basis in schools. Other potential causes are increasing socioeconomic inequalities creating family pressures and stress, and the pressure on young people (both externally and self-imposed) to perform well in and outside school. Young women in particular are believed to suffer more from demands to succeed in all domains of life – looking good, being attractive and doing well at school. However, no solid data or multifocal studies have yet been able to verify any of these suggestions.

Most young people (56%) turn to their parents as their first choice when needing help and support, with friends second (46%) and siblings third (25%). Bullying, stress and the environment in school are among the everyday issues that crop up in conversations with children in groups. Stress affects girls to a greater extent than boys and they feel more pressure as they get older: 68% of 16- and 17-year-old girls feel they are stressed every week. About 47% of 15-year-old girls have headaches once a week and 55% have felt “down” at least once a week during the preceding six months. Young people say that a high workload at school, pressure to succeed, lack of empowerment and the loud noise levels at school may be contributory factors.

Summary of the health of young people in Sweden

Sweden has a long tradition of successful strategies to maintain and improve the health of young people through the use of traditional public health measures such as developing health-promoting laws and policies, imposing legal age limits for alcohol and tobacco use and maintaining high prices, controlling illegal substance use through supporting prevailing cultural beliefs and providing education and healthy lifestyle information through schools and youth health centres.

Youth-friendly health services are offered at the youth health centres. Access is easy and free of charge for those under 20. The underserved population is boys, who have not been attracted to the centres.

The present health problems are high use of alcohol, increasing rates of STIs, especially of Chlamydia, and a high abortion rate among females up to the age of 20. Mental health problems have increased during the last decade and are causing great concern. Various stress-related problems, such as headaches, depression and eating disorders, have increased remarkably, particularly among young women. Traditional medical services, prevention and health promotion strategies do not seem currently to have the answers to these challenges.

A paradigm change in promoting young people's health

Recent advances in the knowledge of brain development during adolescence

Modern brain imaging techniques which allow scientists to follow brain development longitudinally in healthy adolescents have provided us with important insights into why young people behave the way they do (5). This knowledge might make us consider paradigm changes to our approaches, with new principles to add to older tried-and-tested methods of helping young people stay healthy.

In contrast to earlier beliefs, it is now known that substantial neuromaturational processes occur during adolescence. Magnetic resonance imaging has demonstrated disproportionate growth in the hippocampus area, which controls emotional intensity and sensation-seeking. The grey matter of the brain decreases in volume, particularly in the frontal, prefrontal and parietal regions, which underlie cognitive processes and allow young people to exercise inhibition. Myelination of neurons continues into young adulthood and increases cognitive abilities. There is also important synaptic “pruning” during mid-adolescence, a very interesting phenomenon which results in greater efficiency and allows for regional specialization and maturation.

Connectedness: a new paradigm for young people's health

Advances in the knowledge of brain development during adolescence have influenced dramatically health promotion strategies in recent decades. The psychological implications of the changes in brain functioning are far from understood, but already it is clear that traditional life-skills programmes and educational methods delivered in schools are insufficient to guide young people when interacting with peers outside the classroom and when taking part in activities that provoke strong emotions. High-intensity emotions simply overrule the inhibitory pathways. Young people just get carried away.

So, armed with this knowledge, what new principles should we employ to help young people to be healthy? We know that while many traditional methods have proved their worth, other strategies are ineffective. Life-skills programmes, role playing and other sorts of popular “state of the art” programmes have shown limited results over the long term. For example, the Hutchinson smoking-prevention trial combined several well-evidenced methods to stop young people from starting to smoke cigarettes, but showed no efficacy after two years (6). Giving information to young people about risks to health has proved insufficient. By contrast, solid and robust methods, such as legal sanctions and price regulations, are still believed to be effective (7).

The challenge today is to offer young people information and education on health matters when they ask for it, which means that Internet-based health resources offer a great advantage. Web sites have been developed for immediate access over the Internet in many countries. The United Kingdom web site “www.teenagehealthfreak.org” is a good example, as are “www.ciao.ch” from the University of Lausanne in Switzerland and the Russian Federation’s “www.adolesmed.ru”. An official Swedish web site, “www.umo.se”, was launched in 2009.

New methods and strategies are emerging, based on theories arising from knowledge of neuronal development and cognitive maturation of the adolescent brain. These theories, combined with understanding of the importance of exploration during adolescence in search of identity and lifestyles that feel authentic, provide the basis for the development of new paradigms.

One important recent paradigm involves providing safe and healthy environments that allow exploration and also allowing a mental “space” of participation and connectedness. These qualities are believed to be instrumental in promoting healthy development.

Connectedness in three domains is what seems to matter. The three domains are family, school (or workplace) and important people you meet in spare-time activities. To be connected in this sense means having an impact on what goes on, being listened to and being able to influence, even being cared for or

being important to some other person. The more connectedness experienced in more areas by a person, the better it is for his or her mental health, as more resources are available to support healthy development. But even one area of connectedness is helpful in achieving better health (8–10).

Varieties of these principles have already been put in practice, and some evidence of their efficacy is beginning to emerge. A Swedish study of three communities is one such early study (11), and the Gatehouse project from Australia is another, now classic, example (12,13).

In the Swedish study, one municipality consistently provided safe and fun environments for young people. The theory was that young people need to meet many others in order to explore their identity, but that the exploration needs to be conducted in safe and stimulating environments. The municipality provided meeting grounds, engaged adult mentors, worked intensely with school drop-outs, tackled bullying, devised camps in which young people could discuss life values and worked with police to stop illegal drug trafficking, among other activities. Quality of life, satisfaction with school and mental health indicators were much better and substance use was lower than in two very similar communities with no such strategies; and this was delivered with no extra cost to the participating municipality.

The conceptual framework of the Gatehouse project derived from attachment theory and focused on three aspects of the school social context: security, communication, and participation. The project addressed the social context of high school with the aim of changing students' sense of school connection and, in turn, their health-risk behaviours and sense of well-being. The largest effect was a reduction in regular smoking by those in the intervention group, but there was no significant effect of the intervention on depressive symptoms or social and school relationships two years after the start of the intervention.

Connectedness in the Convention on the Rights of the Child

Promotion of human rights is important in improving health for populations throughout the world. Implementation of the *European Convention on Human Rights* (14) offers roads to health improvement through the assertion that “human rights” includes rights to health. An obvious example of this in action can be found in the field of sexual reproductive health for women, where WHO has taken a stand to decrease perinatal mortality as a human right for women.

The United Nations *Convention on the Rights of the Child* (CRC) (15) is an important tool for promoting the health of children and young people through similar principles. This convention, published in 1989, is ratified by WHO and all countries in the world, except for two.

The CRC contains many articles that focus on children's health and several that ought to have a substantial influence on health care and medical treatment. Article 24 accords children the right to the highest attainable standard of health, medical care and rehabilitation. Article 23 gives disabled children the right to enjoy a full and decent life. Children must be protected from all forms of physical or mental violence under Article 19, and Article 33 states that all children have the right to grow up in a drug-free environment.

But while the detail of the convention is crucial, its spirit, which actually promotes connectedness, is also important. It defines children's right to participation in accordance with their level of maturity, including having the right to express their views (articles 12–14), the right to information (the right to access media and get information from all sources), and the right to connectedness to both parents. These are things we now consider instrumental in promoting health in young people

The focus of this case study is therefore how use of the CRC improves the health of children and young people in Sweden.

Swedish experience of using the CRC in improving the health of children and young people

Overview of the CRC in Sweden and the Children's Ombudsman

Even though all nations (except for two) have signed the CRC and have declared their acceptance of its spirit, the CRC is still not a legally binding instrument and may be considered more like a list of recommendations for countries.

This is a problem which needs to be faced. Only when the CRC becomes a legally binding instrument will it have its full effect in promoting children's rights and, specifically, children's rights to health.

The CRC was ratified by the Swedish Government in September 1990. In 1993, the role of the Children's Ombudsman was created.

“Ombudsman” is a Swedish word that has been adopted into the English language. It means to empower a certain group of citizens, in this case, all those under the age of 18. In many instances, ombudsmen are lawyers, which gives them power to deal with maladministration in an effective way.

According to the Children's Ombudsman Act, the Children's Ombudsman is charged with representing the rights and interests of children and young people against the background of Sweden's commitments under the CRC. The Children's Ombudsman is required to drive the convention's implementation, monitor how it is observed and make suggestions on how the CRC or its specific articles can be incorporated into Swedish law, but has no power over other government bodies.

The Children's Ombudsman also has a role in educating the public and participating in debate in the country around children's rights. It enters into dialogues with relevant bodies, provides workshops and lectures and visits agencies on invitation. It initiates investigations when needed and reports on its findings and delivers an annual report focusing on issues requiring special attention. It is important to emphasize, however, that the Children's Ombudsman never deals with the rights of individual children.

The key issue is that children's perspectives must permeate the whole of society and the consequences for children in all decisions affecting them must be analysed. Representing children and young people naturally presupposes good communication with them, listening to them and taking their opinions seriously, but that in itself is not sufficient, according to the Children's Ombudsman. The child must also be accorded full and equal worth as a human being, the same worth as an adult. Adults' attitudes to children and young people and the way they lead their lives pose a big challenge to enacting this fundamental principle.

The Children's Ombudsman has direct contact with children and young people of different ages and in different contexts. There are 190 contact classes (over 2000 individuals) through which young people's views on different issues can be explored. There are also nine children's councils and one youth council for regular focus discussions. But this structure also poses a challenge. As one participant said: “I am not coming to these meetings if all we do is talk. I want some action”.

The Children's Ombudsman initiates research in which children and young people are asked directly for information and opinions. This has become an important route to helping children and young people to have a real impact on action, but regular direct contact with young people, rather than indirect contact through representatives, is still unique in the area. The work of systematically applying a children's perspective in decisions and measures that concern children has nevertheless been progressed in a number of government authorities, county councils and local authorities.

The Children's Ombudsman engages in both top-down and bottom-up activities. The former applies to actions that influence national, regional and local bodies to promote the incorporation of CRC principles and children's interests in policies and regulations. Bottom-up activities are those that grow from direct

communication with young people.

Top-down activities carried out by the Children's Ombudsman

So far, progress on incorporating CRC principles in all levels of public affairs at regional, county and municipal levels has been slow, according to several audits. For instance, half of the country's social welfare authorities did not have children's perspectives included in their objectives for 2008.

Several Children's Ombudsman reports and activities have focused on the judicial system, with a report produced in 2006 claiming that the legal system was not designed to meet children's needs. More specialization is needed on the part of judges who try cases in which children are involved. Judges should know about psychological development in children and be aware of research into, for example, ways of interviewing children and how the conduct of the interview affects the child's testimony. Special knowledge is required to competently evaluate cases in which criminal acts and violence have been committed against children and also in custody cases, where parents are contesting against each and the judge needs to understand the balance between children's need for stability and their need for access to both parents.

The Children's Ombudsman has consequently initiated courses for criminal investigators on how to interview children and young people who have committed crimes and who are victims of crime, especially those in emotionally distressing situations, such as having to testify against their own parents.

A novel approach was a manual published in 2006 which aims to explain to young people, whether they are victims, witnesses or perpetrators of crimes, the intricacies of court procedures to help them understand and participate in those procedures.

Legal procedures and young people

Young people are often involved in legal procedures without representation and with scant regard for their rights. This occurs in custody conflicts and when a young person is being taken into custody because of failure in the family to provide adequately for him or her, or because of improper or criminal behaviour on the part of the young person.

There is no legal duty for courts to talk to a young person under 15 years. He or she has no lawyer speaking for him or her; in fact, nobody looks specifically at the best interest of the child, even though some might have good intentions. Children may be allocated a legal assistant paid for by the state, but this is not obligatory. The Children's Ombudsman has worked persistently to change this.

Informing children about their rights

Society in general assumes that parents and guardians have the best interests of the child as a main objective. Swedish law is based on this assumption, but it is far from true. For this reason, it is important that children and young people have rights, know how to execute them and know where they can go for help.

The Children's Ombudsman has produced three information booklets called "I have something to say", one for children aged 5-9 years, one for 9-13-year-olds and one for 13-17-year-olds, complemented by manuals for teachers. The language is skilfully adapted to the relevant age group and funny and informative illustrations are used to make the booklets interactive, with quiz sections and discussions about ethical values. Some schools opt to celebrate United Nations' Day in October by focusing on the booklets.

However, the picture is not quite so bright regarding children's and young people's general knowledge of the CRC. This was demonstrated in a survey in 2009 (16) in which only 22% of 11- and 14-year-olds knew about the CRC, which actually represents a decrease from 2007, when 28% said "yes" to this question. Of those who said they had or "maybe" had heard of the CRC, only 17% stated that they knew what it was all about.

One set of questions asked about the sources of their information on rights. Teachers (42%) were the most common source, second was “nobody” (36%), and parents were third (24%). It looks as if the effort to involve teachers has paid off, but more can be done, such as incorporating the CRC into the teacher-training curriculum, as has been suggested by the Children’s Ombudsman. The fact that 36% of children and young people who knew about the CRC did not know how they had accessed the information must be interpreted as an indication that the CRC is part of the general discourse going on in society.

The Children’s Ombudsman has suggested that educating parents about the CRC may be a route to teaching children about their rights. One complication might be that young people from immigrant families sometimes threaten their parents with reporting them to social services for abuse and denial of their rights. Sweden has a strict law against corporal punishment of children, a fact that is made known to immigrant families, but families from non-northern areas who were brought up under a strict disciplinary code might become confused about how they can discipline their children in a country which deems traditional methods unacceptable. So teaching immigrant families about the CRC, but at the same time discussing parenting styles, might help to promote CRC in these families and also halt the practice of young people using CRC against their parents.

Young people’s knowledge and preferences regarding their rights

Despite denying knowledge of the detail of the CRC, young people were well aware of its spirit, as the 2009 Ombudsman’s report shows (16).

Over 90% reported that it was important for them to be able to:

- be allowed to sing, dance, draw, paint and do other things which are fun
- play
- live in clean, healthy environments
- feel safe
- have contact with both parents
- ensure that people do not spread lies about them
- be treated as equal to other young people
- know who their parents are
- believe in whichever God they like, or none
- learn how to avoid accidents.

Between 70% and 90% reported the following things to be important to them:

- seeing art exhibitions, listening to live music and going to the theatre
- having quality radio and television programmes specifically for them
- being left alone when they want to
- being allowed to state their opinions on matters that concern them
- being able to voice their opinions to others
- belonging to whichever organizations they wish.

Fewer than 20%, however, thought that young people should decide what they should learn in school, whether they should have homework or not, and how late they should be allowed to stay out at night.

Young people’s experience of being respected

The question of whether young people feel respected and taken seriously when they have something important to say elicited the following responses (16):

- 95% felt respected by their parents
- 76% felt respected in school
- 47% felt they were listened to when visiting primary care centres

- 41% felt respected within sports associations
- 24% felt respected in public libraries
- 15% felt respected in shops and on public transport
- 10% did not believe that adults considered children to have equal value
- 2% did not believe their parents considered children to have equal value.

Young people in custodial care or in criminal institutions rarely felt respected or that they were being treated in accordance with the CRC.

Young people's opinions about the health care system

The Children's Ombudsman has been hesitant to become directly involved in health management, as there are several powerful lobby groups representing different patient organizations, including the parents of sick children. But the child's perspective in health care and medical treatment is important.

The 2009 annual report (16) showed that children and young people believed in their right to get help when they are sick, to live in a healthy environment and to be informed on how to prevent accidents, but only 49% felt sure that they would get help when feeling very sad, scared or worried. Sixty-four per cent stated that they definitely wanted the school nurse practitioner in school every day which, as was discussed above, is not always the case.

Only a quarter of the small group who had been to a child and adolescent rehabilitation centre felt they had been able to influence their treatment. This is remarkably low compared to the proportion of young people who felt they had an input into discussions and treatment in other medical services. Earlier Children's Ombudsman reports have shown that many children and young people treated in rehabilitation services do not know the purpose of the treatment.

Bottom-up activities: illustrating the importance of giving young people a voice of their own

Bottom-up activities relate to those actions from the Children's Ombudsman that directly interact with children and young people across different aspects of their lives and consequently provide them with a channel through which they can express their needs, worries and suggestions for change.

Young people's experiences might be quite different from what professionals in charge of a specific area may think.

In the survey from 2008 (17), young people were asked whether they were listened to and felt able to influence their medical treatment. About four out of ten who had attended child and adolescent mental health services answered that they had been able to influence their treatment, but when the heads of the country's child and adolescent psychiatric clinics were surveyed in 2004, all of them said that it was important that treatment be given in consultation with the children and young people, and nine out of ten said that children and young people could influence their treatment.

Young people with functional disabilities

CRC Article 23 grants children and young people with functional disabilities the right to a full and decent life with dignity, satisfaction and active participation in society.

The Children's Ombudsman has studied and reported on various aspects of how this works in reality for disabled young people, pointing out that the quality and suitability of personal assistants needs to be assessed. The assistant is alone with the young person for hours at a time and the risk of inflicting physical and psychological maltreatment is always present. Assistants must have adequate knowledge of the specific needs of the disabled young person, with the responsibility for transmitting this knowledge laid at the door of parents, school personnel and rehabilitation specialists. Frequent changes of personal assistant is identified as a problem.

Young people with severe disabilities and functional disorders have the right to a personal assistant to support them inside and outside school. This is a positive development, but as the Children's Ombudsman's report of 2004 shows (18), having a personal assistant is complicated. It reports a qualitative study in which young people were asked about the experience of having a personal assistant. They saw the dependence it created as problematic and questioned why they needed an assistant. They felt embarrassed to ask for help for bathroom visits, especially from assistants of the opposite sex, and felt that some assistants acted as "extra parents", taking over and making decisions for them. Their "dream assistant" was under 25 years of age, of the same sex, and did not make their decisions for them. They also wanted to choose the assistant themselves.

The Children's Ombudsman has consistently reported that young people with functional disabilities say they have problems accessing spare-time activities. They have the right to taxi services for necessary activities, but while young people can relatively easily access the service to attend school, it is more difficult to do so for spare-time activities, with differences in how "liberally" local services view their responsibilities. The Children's Ombudsman argues that this situation is not in agreement with CRC Article 23 and advocates for the best interests of the child to be written into the regulations on rights to taxi services.

Another serious obstacle to young people with functional disabilities is that many public buildings are still not accessible, and there is a lack of suitable spare-time activities, especially in small communities (2).

Almost all municipalities have councils for people with special needs ("Handikappråd"). The Children's Ombudsman investigated how these councils canvass young people's opinions and needs, which it published in the annual report of 2004 (18). Ninety per cent of the municipalities and city subdivisions answered the questionnaire, and it was shown that direct input from young people existed in only 25% of councils. It was more common for the views of young people with disabilities to be represented by their parents or by NGOs for specific disabilities. In a follow-up study four years later, the situation had not improved, with only 22% of councils having young people involved (17).

Young people with an incarcerated parent

Young people have the right to both parents, and the CRC states that countries should do what they can to make this possible. When one parent is in prison, this right is jeopardized. An investigation in 2003 by the Children's Ombudsman showed that only 60% of prisons had proper facilities in which parents and young people could meet.

Young people with parents in prison care about their parents and worry about them. Actually seeing them in somewhat normal conditions helps to ease these concerns. The Children's Ombudsman has argued for free telephone calls from inmates to their children and allowing children to call their parents, which helps normalize relationships. Education of inmates on helpful parenting styles is another way to support young people.

Violent parents

Children should always be protected from a violent parent. Swedish courts have often acknowledged parents' rights to their children, which might not be in the best interest of the child. The Children's Ombudsman has argued for risk and safety assessments for children in such cases.

Young people can also witness violence within the family, which can leave them particularly physically and psychologically vulnerable. According to the Children's Ombudsman, children and young people in this situation should be provided with medical and psychological support. Swedish law should be changed so that this is possible even if it is against the wishes of the parents. Legislators are now discussing this issue.

Children and young people also need their legal status enforced by providing them with legal assistance as independent partners in their own right in family conflicts; this would help them to determine what is in their best interests for the future.

Helplines

There are some free helplines for young people in Sweden. The Children's Ombudsman receives calls about abuse of children, but the majority of calls probably go to the Save the Children Foundation, Barnens Rätt i Samhället (BRIS) [Children's Rights in Society] and other NGOs. One may assume that those who use helplines are desperate and helpless.

BRIS, one of the first helplines for children and young people in the world, respects the confidentiality and wishes of the young person calling. BRIS recorded 22 000 contacts in 2008, of which 31% were from boys. The average age of callers was 14.3 years. Physical abuse at home was reported in 8.5% of contacts, and another 4% reported psychological abuse.

Communication with BRIS was in itself helpful for the callers. The dilemma facing BRIS call-handlers is that the actions they could initiate in response to acts of serious abuse, such as criminal investigations and foster family placement, are not necessarily what the callers are seeking. The callers are looking for help for their families, but they know that if they report the abuse to school or social services, punitive actions would ensue. So the aim of BRIS is to help them understand that they should not, and must not, tolerate such abuse.

Young people in custody

Children and young people who are in custody or foster care because of misbehaviour comprise a vulnerable group with low social status and few stakeholders. In 2003, the Children's Ombudsman and the county of Skåne performed an interview study of young people in custody to find out if they had the potential and opportunity to influence their situation. Seventy-three young people aged between 11 and 18 years participated.

Most young people knew and accepted the reasons for being in custody. Many liked their time there, but a few said that nothing was good about their temporary placement. More than half the participants said that staff never (or rarely) discussed the rules of the institution and never asked about their school performance, spare-time activities or friends and family. Only 68% knew about rules and plans for their stay, even though it is mandatory that this information is given to them.

Young people in custody have the right to meet with their social worker regularly, but only 44 % had had contact once a month or more frequently. Sixteen per cent had never had contact, or had so less than once every six months. This is against the rules for custodial care.

Many of the young people said that they were worried about their families and also about younger siblings still at home. A problem mentioned by some participants was the use of illegal drugs in institutions and the risk of the young person being introduced to drugs and other criminal behaviour while in custody.

Scientific studies have demonstrated that custodial care does not benefit young people if they do not see the meaning of it or if they have no influence on the care they receive. Suggestions for improved care from young people in custody included:

- more spare-time activities, excursions and access to youth centres offering different activities
- early detection of problems by schools
- provision of contact persons for social support and protection.

The results of this study have been presented and discussed at many workshops and roundtable meetings since its publication. It seems obvious that it has had an impact on the care given in custody, and several cases of unacceptable conditions in custodial homes have been reported in the press. Discussions on how to improve custodial care by making quality assurance of homes mandatory, improving training for personnel and taking appropriate legal measures are now well advanced.

Immigrant children, children arriving alone and illegal immigrants

Many NGOs in Sweden are providing support to these children, who are subjects of high public controversy. The Children's Ombudsman has been engaged mainly in ensuring the legal process applied to them is fair and in providing them with legal support. Even "undocumented" children have rights to access to health care and school.

In 2009, the United Nations Committee on the Convention on the Rights of the Child inspected the work done in Sweden over the previous five years and found cause for criticism in relation to its asylum procedure. The main issue in Sweden is whether children have more rights to asylum than their parents. At the current time, they have equal rights to their parents, but if they were to be granted greater rights to asylum, they would still have the right to access to their parents under the CRC, which means their parents, too, would need to be granted asylum.

Homeless young people

There are not many homeless young people in Sweden, and very little is known about them. Most engagement with them is through NGOs.

The majority are homeless with their parents following eviction from their home for failure to pay rent. Twice as many girls as boys run away from home, with girls from immigrant families overrepresented. One in three homeless adults has children, but this does not necessarily mean that their children live with them on the streets. The Children's Ombudsman is aware of the problem.

Health promotion

If having an impact on, and being connected to, the three domains of family, school and spare-time activities are accepted as health promoting strategies, then the Children's Ombudsman is engaging in health promotion activity.

Several activities have allowed young people to have their voice heard, which is promoting connectedness. This is especially true for vulnerable groups that traditionally do not fight for their rights and who are marginalized in conventional health and welfare systems.

The Children's Ombudsman has been able to give children and young people a voice over the years. It speaks with the insight of what children actually think and feel about different issues, which is then translated into strong arguments to promote change.

Other agencies, government bodies and networks working with participation of young people

The Children's Ombudsman is not the only institution speaking for young people. Several other institutions and NGOs have also taken the initiative to give young people a voice. Promoting participation among youth is a common approach among many organizations and is in line with policy declarations from the parliament and government.

Youth councils are common in municipalities, and the trend is growing. Representatives of young people, usually elected in school or from youth organizations, serve as reference groups for local governing bodies and come up with suggestions for action. Many such councils, however, only have an advisory role, and their impact is low.

Evaluations have shown that youth councils in which young people have responsibilities for particular areas of policy and are granted a budget to support implementation become successful democratic institutions, working in the spirit of the CRC.

The Swedish National Board of Public Health has the promotion of participation and "affiliation" with society, particularly for children, young people and older people, as the first of its 11 objectives. Its third

objective is to promote the health of children and young people.

The Swedish National Board of Youth Affairs, which was created in 1959, aims to promote young people's influence in society and increase their access to welfare support in line with decisions from the Swedish parliament and government.

Both of these institutions promote equality and stress the need for support of marginalized groups, such as women and minority groups. Both work by transmitting knowledge and collaborating with other organizations, such as the National Association of Municipalities, Counties and Regions, to promote their goals.

This indirect mode of operation is typical of organizations that are interested in promoting young people's participation. Schools, for instance, have had school councils, in which each class selects one representative, for years. But while these councils work hard to promote direct involvement of students, they experience difficulties in having a direct impact on school management. The Children's Ombudsman commented on school councils in the 2004 annual report (18), arguing for direct involvement of teachers with individual students.

Most organizations that promote youth participation do not interact directly with young people. Instead, they do so through organizations that represent young people or are run by them. Young people involved directly in youth councils at various levels undoubtedly benefit personally from being empowered and connected, but the benefits to those they represent can be questioned.

This review has found only two examples of direct intervention with young people (apart from the activities of the Children's Ombudsman). One comes from the Board of Youth Affairs, which developed a questionnaire to be used by municipalities to find out what young people think and need. It taps areas such as satisfaction with spare-time activities offered by the municipality and school satisfaction. It particularly highlights bullying, plans for the future (focusing on whether young people have an interest in remaining in the municipality for studies or work and also if they feel that they have an impact on the local community), and whether they would like to meet with local politicians (very low interest in this was reported in three communities!).

And an innovative direct approach has been made by the Minister for Youth Affairs, who placed a question on the Internet over six weeks of 2009 and invited all young people to respond. This "question about the future" asked young people to communicate what they think is important for the government to do. It can be accessed at: <http://www.framtidsfragan.se>.

In addition, BRIS and other helplines for young people offer opportunities for direct participation to young people in distress. Reports and press releases from these helplines are highly visible in the media.

Conclusion

This has been an unusual case study in the sense that it has not identified a problem, described policies and actions taken and reported outcomes. Rather, the case study has focused on promoting the rights of children and young people by describing the actions of a government body that has been given the mandate to do this over 15 years. It has presented an argument to demonstrate that while young people enjoy rights, they have by and large not been allowed to act as experts on their own experiences and beliefs. Their voice has been heard selectively via indirect means, through representatives, organizations and parents.

It has argued that promoting rights for young people is tantamount to promoting health. Connectedness is the core, and it is the key solution. Young people's connectedness to society is promoted when society listens to them directly and acts on their views. The Children's Ombudsman has pursued this approach through direct interaction with groups of young people, including groups of the most vulnerable.

And while little progress has been made in the area of mental illness for young people in the last 10 years, some important advances have been seen in relation to vulnerable groups. Neglect of the rights of young people in custody, for instance, is now on the main public agenda in Sweden. Many prosecutors and judges have taken courses on child development initiated by the Children's Ombudsman. Municipalities are repeatedly reminded of the importance of equal rights for children and young people with disabilities. And a government minister has interacted directly with young people via the Internet on a specific political question.

There has been a paradigm shift in Swedish society, with a new willingness to listen to young people and take them seriously being evident. The growth of youth councils in most municipalities is a clear example of this in practice, although many of them currently play only an advisory role. One cannot argue that the Children's Ombudsman alone has engineered this shift, but the Children's Ombudsman has been instrumental in developing its momentum. It probably remains the agency that most consistently listens directly to individual young people.

This change in society will benefit young people and, in the long run, will help many of them to be better connected to society and, hopefully, to enjoy better health.

Author's note

The author has used official Swedish web sites to access facts and statistics. Reports of objectives and modes of operation of government agencies and others cited in the text have been taken from their own official web sites and translated into English by the author, when necessary. Most of the information on the web sites is available only in Swedish.

Analyses of activities, interpretations of their impact on the health of young people and the conclusions drawn are based on the author's own knowledge, experience, expertise and opinions, and have not been discussed with, or approved by, the agencies involved.

References

1. Att förebygga oönskade graviditeter: Kartläggning, beskrivning och analys av verksamhetens arbete med unga och unga vuxna [Preventing unwanted pregnancies. Identification, description and analysis of activities working with young people and young adults]. Stockholm, The National Board of Health and Welfare, 2008.
2. Barnombudsmanens årsrapporter 2002 [Children's Ombudsman annual report 2002]. Stockholm, Children's Ombudsman, 2002.
3. Hvitfeldt T, Nyström, S. Skolelevvers drogvanor; 2008 [Substance use by schoolchildren, 2008]. Stockholm, Central Association for Alcohol and Other Drugs, 2008.
4. Forsberg M. Ungdomar och sexualitet [Young people and sexuality]. Stockholm, Swedish National Institute of Public Health, 2006.
5. Dahl RE, Spear LP, eds. Adolescent brain development. Vulnerabilities and opportunities. New York, NY, New York Academy of Sciences, 2004.
6. Clayton RR, Scutchfield FD, Wyatt SW. Hutchinson smoking prevention project. A new gold standard in prevention science requires new transdisciplinary thinking. *Journal of the National Cancer Institute*, 2000, 92:1964–1965.
7. Viner R, Macfarlane A. Clinical review. ABC of adolescence. Health promotion. *British Medical Journal*, 2005, 330:527–529.
8. Duncan PM et al. Inspiring healthy adolescent choices: a rationale for and guide to strength promotion in primary care. *Journal of Adolescent Health*, 2007, 41:525–535.
9. Blum RW. Healthy youth development as a model for youth health promotion. A review. *Journal of Adolescent Health*, 1998, 22:368–375.
10. Resnick M et al. Protecting adolescents from harm. Findings from the national longitudinal study on adolescent health. *J Am Med Assoc*, 1997, 27:823–830.
11. Berg-Kelly K et al. Health habits and behavior among youth in three communities with different public health approaches. *Scand J Soc Med*, 1997, 25:149–155.
12. Bond L et al. Building capacity for system-level change in schools: lessons from the Gatehouse project. *Health Educ Behav*, 2001, 28:3:368–383.
13. Patton G et al. Changing schools, changing health? Design and implementation of the Gatehouse project. *Journal of Adolescent Health*, 2003, 33:231–239.
14. *European Convention on Human Rights*. Strasbourg, Council of Europe, 1954 (<http://www.hri.org/docs/ECHR50.html#Convention>, accessed 4 September 2009).

15. *Convention on the Rights of the Child*. New York, United Nations, 1989 (<http://www.unicef.org/crc/>, accessed 4 September 2009).
16. *Barnombudsmanens årsrapporter 2009 [Children's Ombudsman annual report 2009]*. Stockholm, Children's Ombudsman, 2009.
17. *Barnombudsmanens årsrapporter 2008 [Children's Ombudsman annual report 2008]*. Stockholm, Children's Ombudsman, 2008.
18. *Barnombudsmanens årsrapporter 2004 [Children's Ombudsman annual report 2004]*. Stockholm, Children's Ombudsman, 2004.

Switzerland: certifying an adolescent friendly unit –is there an added value?

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Executive summary

The Unité Multidisciplinaire de Santé des Adolescents (UMSA) of the University Hospital in Lausanne was created in 1998. Its mission is to:

- provide comprehensive health care for adolescents aged 12 to 20 years
- foster epidemiological and clinical research
- provide training sessions at undergraduate and postgraduate levels
- serve as a reference centre in the field of adolescent health.

Around 12 people work in the unit, seeing 700–800 adolescents a year and complying as much as possible with the criteria for youth-friendly health services.

In 2005, the staff of the unit decided to embark on a voluntary certification process. The unit is required under the certification process to describe the main procedures developed to assure an ongoing assessment of the quality of its activities. This is reviewed by an expert who decides whether the documents provided by the institution meet specific standards in terms of the feasibility, validity and reliability of performance indicators.

After a nine-month process, the unit gained certified status via an independent specialist agency. Procedures have now been developed, refined and monitored and have proved very effective in improving the quality of health care and in strengthening human resources management and budgetary control. All staff are involved in the process and take the view that there is added value in implementing the quality management tool in the unit.

Introduction

In 1996, the Department of Paediatrics and the head of the University Hospital of Lausanne, Switzerland decided that something should be done to improve the health of adolescents in the region. Hospitals of the canton (county/administrative region) were faced with an increasing number of admissions for conditions such as obesity and eating disorders, unstable chronic conditions, unplanned pregnancies, sexually transmitted infections (STIs), alcohol-induced coma, injuries and suicidal behaviours. Practitioners increasingly felt ill-prepared to cope with these new morbidities, leading to a sense that adolescent health and medicine should be put on the undergraduate and continuing professional education agendas of health care professionals.

Consequently, the Unité Multidisciplinaire de Santé des Adolescents (UMSA) was opened in January 1998. Its mission is to:

- offer an adolescent-friendly unit for adolescent care;
- foster clinical and epidemiological research (in collaboration with an affiliated research group focusing on adolescent health);
- provide teaching courses at every level of the training curriculum of doctors, nurses and other professionals; and
- become a centre of reference in the field of adolescent health, both at individual and public health levels.

The outpatient unit is run by a growing multidisciplinary team of around 12 professionals who provided

more than 4000 consultations in 2008. Most patients present with complex situations requiring a multidisciplinary approach, including eating disorders (25% of the case-load), chronic conditions, concerns about growth and puberty, functional disorders and substance misuse. Around 35% of patients consult for gynaecological problems, including menstrual disorders and planned or unplanned pregnancy.

Currently, the research group publishes six or seven papers yearly in peer-reviewed journals. UMSA staff deliver 300–400 teaching sessions each year for students, doctors, nurses and other professionals and coordinate a training programme called EuTEACH (which stands for “European training in effective adolescent care and health”). EuTEACH has a freely available web site (<http://www.euteach.com>), offers a one-week international training course annually and provides advice, services and evaluations in the fields of school health, public health and policy development. A special consultation dedicated to the care of male adolescents facing pubertal and sexual issues was launched in 2005.

All these activities require a collaborative approach within a wide network of institutions, including the Department of Child and Adolescent Psychiatry, schools, foster homes and social services.

The certification process

Quality management is a major concern within the University Hospital. More and more departments and units are being encouraged, on a voluntary basis, to embark on programmes designed to improve quality, including, in a limited number of cases, a formal certification process.

UMSA’s staff decided to initiate a certification process in 2005, along with International Organization for Standardization (ISO) standards (<http://www.iso.org/iso/home.htm>). The decision was taken following a staff vote, as it was felt that the process would involve all members of the unit and that everyone should understand that it would require special effort.

The certification process requires institutions to describe the main procedures for ongoing assessment of the quality of its activities. This is reviewed by an expert who decides whether the documents provided by the institution meet specific standards in terms of the feasibility, validity and reliability of performance indicators. It is important that the whole process is conducted voluntarily.

A researcher who had already worked in the certification process of a health institution was appointed to monitor the process and assist the members of the unit in discussing the content of the documents describing quality management. The ISO 9001–2000 norm was proposed by the agency which certifies health care institutions in Switzerland as the reference for this course of action.

Staff had numerous meetings to check the progress of the work over a period of around nine months. In June 2006, the unit was certified by the Swiss Association for Quality and Management Systems (<http://www.sqs.ch/en/index.htm>), an independent agency specializing in the certification of health services. All the main activities of the unit were included in the certification – health care, research and public health activities, as well as managerial aspects.

Currently, a senior member of the secretariat is in charge of the maintenance of the quality management process, which she does with the support of three other members of staff (including the chief physician director of the unit), meeting once a month for a review. While the opinion of young people is often elicited when new activities are planned (through focus group discussions, for instance), it was felt that their input in such administrative work would not be useful.

Management of health care quality

The two main activities reviewed were health procedures in specific situations and institutional collaboration.

There is consensus currently on how young people should be received and treated within youth-friendly health services (YFHS). UMSA staff have developed a chart that is displayed at the entrance to the unit,

along with the YFHS guidelines. This chart stresses issues such as confidentiality and the importance of involving parents as much as possible in the care of their adolescent children. It also insists on reinforcing the autonomy of consultants and improving their decision-making capacity in this field.

The chart is discussed and re-evaluated during the biannual staff retreat, during which all the processes of the unit are reviewed. It is therefore not a static document, but provides a foundation for ongoing improvement. The unit has now asked the research group to survey the satisfaction of adolescents and their parents coming to the clinic.

Apart from establishing the unit's basic principles and ethos, staff have also focused on the content of the consultation and how to respond to specific situations. Several documents emphasize a holistic or global approach to adolescent patients, combining a focus on the reason for the visit with a broader exploration of the adolescent's health and lifestyle. While this basic approach to adolescent health care has achieved consensus, there is currently little evidence on how to address many of the clinical situations which may present.

For instance, it could be argued that there are currently few evidence-based sources identifying the most effective way to treat anorexia nervosa or functional disorders, or how to provide advice to modify risk-taking behaviours. It was therefore difficult to develop evidence-based guidelines to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances. It was nevertheless decided to review the available literature and to compose health care protocols on the key areas dealt with in the unit to guide young resident doctors in their everyday work. The unit therefore has an agreed description of how to treat adolescents with conditions such as substance misuse, eating disorders, suicidal behaviours, functional disorders and dysmenorrhoea; these contribute to efforts to increase quality and develop consistency of care within the unit.

The unit receives many adolescents referred by professionals working in shelters or foster homes, in the school health system or in social services. The treatment of such young patients often requires a network approach involving cooperation with various stakeholders. While the network approach is especially important in the care of high-risk drop-out adolescents or youngsters who are already enrolled in social programmes, it is often a challenge to successfully manage this kind of collaboration. For instance, one has to balance the need for confidentiality against recognition of the need for professionals to know about the different issues in a given situation. The issue of how and when to transmit information, and to whom, is also highly sensitive.

To address these potential problems and improve the partnership approach, the unit has worked with the staff of all main collaborating institutions to establish a protocol outlining precisely what each institution expects from the other and detailing the commitments of each partner. These protocols are reviewed annually.

The added value of these discussions has become more and more obvious over time. They have led to decreases in misunderstandings and improvements in the satisfaction of colleagues using the unit's services. In a recent meeting with the staff of a foster home, for instance, the head of the home mentioned that the discussions around, and use of, the protocol had not only improved compliance levels of adolescent girls visiting the UMSA, but had also increased their satisfaction levels with the service.

Improving the quality of the management of the unit

Management of human resources is part of the function of any unit of the University Hospital. Achieving certification has contributed to clarifying the management process, with each employee now having a document detailing the specifications of his or her position. This document is reviewed every year with discussion on whether the objectives set for the preceding year have been met. If they have not been met, the reasons for this are explored and objectives for the following year are agreed. These discussions result in improved satisfaction for employees, better utilization of the specialist skills of all members of staff and a better overall view of the running of the unit for its director. Informal checks are also carried out throughout

the year, according to employees' needs. These regular assessments contribute to the incorporation of new ideas and strategies into the work and progress of the unit.

Following-up on proposals made or decisions taken is often a neglected area in a unit's processes. Problems that need an appropriate response in terms of administrative organization or health care approach quite often arise during individual discussions and staff meetings. The quality management procedures now in place guarantee that each of these problems and its planned solutions are noted and reviewed regularly to determine if the proposed changes have been implemented or not.

Another central aspect of any unit is management of finance. UMSA has recently moved from a system where a fixed amount of money is received at the beginning of the year to a "fee-for-service" system in which the budget is dependent upon the performance of the unit. As a consequence, financial indicators which allow for fine-tuning of all elements of the budget are needed.

The framework provided by certification has been essential in the development of this new financial framework. Indicators have been developed in areas such as:

- the time lapse between the consultation and its registration on the hospital's central computer;
- yearly and monthly invoices billed to insurance against the cost of salaries; and
- the distribution of gains over the years.

Conclusion

UMSA staff have established a set of procedures for all the unit's main activities and have ensured that these procedures are regularly reviewed and, where necessary, revised. It is recognized that certification is an ongoing process that focuses less on the provision of services than on how the unit improves the quality of its performance on a regular, ongoing basis. Certification provides a means through which staff can adopt a critical stance to their service provision and set high aspirations for the nature and quality of services provided.

Four years on, staff feel the certification process, which has been endorsed democratically by all members of the unit, has provided added value to their service. Implementing a certification process is a time-consuming task which should not be underestimated, but the consequent middle- and long-term benefits are important. The participation and "mobilization" of every member of the unit is an important condition for the success of such a process, especially in a relatively small unit such as UMSA.

The management system developed in UMSA has improved the quality of health care procedures and brought more satisfaction to employees. Moreover, it has certainly increased the visibility of the unit within the hospital and within the direction of the hospital.

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Further reading

- American Academy of Pediatrics. The pediatrician and the “new morbidity”. *Pediatrics*, 1993, 92:731–733.
- Elster AB, Kuznets N. *AMA guidelines for adolescent preventive services (GAPS). Recommendations and rationale*. Baltimore, Williams & Wilkins, 1994.
- Epner JE, Levenberg PB, Schoeny ME. Primary care providers’ responsiveness to health-risk behaviors reported by adolescent patients. *Arch Pediatr Adolesc Med*, 1998, 152:774–780.
- Field M, Lohr K. *Clinical practice guidelines: directions for a new program*. Washington, DC, National Academy Press, 1990.
- Goldenring J, Rosen D. Getting into adolescent heads: an essential update. *Pediatrics*, 2004, 21:64–90.
- McIntyre P. *Adolescent friendly health services (draft report)*. Geneva, World Health Organization, 2001.
- Michaud PA et al. The development and pilot-testing of a training curriculum in adolescent medicine and health. *J Adolesc Health*, 2004, 35:51–57.
- Viner R, Keane M. *Youth matters: evidence-based best practice for the care of young people in hospital*. London, Caring for Children in Health Services, 1998.

The former Yugoslav Republic of Macedonia: “I want to know” – a successful model of integrated youth-friendly services for sexual and reproductive health in primary health care

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Executive summary

The idea of creating specific youth centres for sexual and reproductive health reflects the intention of the government and the nongovernmental organization (NGO) Health Education and Research Association (HERA) to integrate health and social services within primary health care and reach out to the most vulnerable young people, including sex workers, men having sex with men (MSM), street and institutionalized children and young Roma.

Integration had to ensure operational and financial sustainability from the state health system beyond donor support, while the NGO's involvement was crucial in ensuring young people's participation in all stages of youth clinic development, accelerating access to services of those who are most vulnerable and marginalized and building the capacity of state service providers on the crucial aspect of young people's sexuality and reproductive health.

The “I want to know” youth centres are special because they provide a wide range of free and anonymous sexual and reproductive health services and counselling that are segregated from other health services at the clinics, enabling young people to feel welcome and safe. Young peer educators are involved inside and outside the clinics, organizing promotional and entertainment events and being involved in evaluation of services to ensure young people are equal partners in service delivery and the promotion of sexual and reproductive health.

Even today, however, the “I want to know” youth clinics are not fully covered within the government health programme and budget. There appears to be a lack of political will to effectively implement adopted policies that acknowledge sexual and reproductive health issues among young people. Ongoing reforms and privatization of primary health care services are not seen to be in favour of introducing and/or integrating specific youth clinics in primary health care settings. New approaches are needed at central and local government levels to better address the sexual and reproductive health needs of young people and to ensure that the new reforms do not negatively influence accessibility to services through decreases in financial support and quality of care.

Socioeconomic background of young people in the former Yugoslav Republic of Macedonia

The former Yugoslav Republic of Macedonia has gone through demographic transition in recent decades in terms of increased ageing of the population and an increase in the rate of older people in the total population. The country's population is still considerably younger than that of countries in western Europe with a median age of 35.3 years, according to the 2002 census, but the number of older people is on the rise. Average ages in the countries of the European Union (EU) and central and eastern Europe are also increasing and the proportion of older people in the former Yugoslav Republic of Macedonia is significantly lower than this average.

Numbers and proportions of adolescents in the population are shown in Table 1.

Table 1. Numbers and proportions of adolescents in the total population

| Age group | Numbers | | | Proportion of total population (%) | | |
|-----------|---------|---------|---------|------------------------------------|-------|---------|
| | All | Males | Females | All | Males | Females |
| 10–19 | 311 614 | 160 361 | 151 253 | 15.27 | 15.67 | 14.87 |
| 10–14 | 149 523 | 76 912 | 72 611 | 7.33 | 7.52 | 7.14 |
| 15–19 | 162 091 | 83 449 | 78 642 | 7.94 | 8.16 | 7.73 |
| 20–24 | 165 305 | 84 763 | 80 542 | 8.10 | 8.29 | 7.92 |

Source: State Statistical Office, 30 June 2006

Key socioeconomic trends and indicators concerning children and adolescents include the following.

- The national unemployment rate is very high (33.8% in 2008), with extremely high youth unemployment (56.4% among 15–24-year-olds) (1).
- There is a high and increasing concentration of poverty among households with children (49.3% in 2002 to 66.6 % in 2005) (2).
- The rate of children in institutional care is increasing: 164.4 per 100 000 population aged 0–17 years in 2002 to 182 per 100 000 in 2005 (2).
- The majority of children (92%) live in traditional families with both parents, with an average of 3–4 members in families originating in the former Yugoslav Republic of Macedonia and 5–6 in families of Albanian or Roma ethnic origin (2).

Data on young people's health and health-related behaviours

In general, basic data about adolescent mortality and morbidity in the former Yugoslav Republic of Macedonia have poor reliability and accuracy. Specific data for the age groups 10–14 and 15–19, data on social determinants of health such as place of residence, economic status and education level, and data on certain morbidity statistics are either not available or are not presented as disaggregated data in official health statistical reports. In addition, data are only available from state-owned health institutions, with those from the private health sector lacking. Currently, there is no national system for systematic data collection on healthy lifestyles among adolescents, meaning the data that are available arise from random health surveys. It is essential that this situation is resolved.

Available data on young people's health from the former Yugoslav Republic of Macedonia can be grouped under the following headings.

Mortality

The mortality rate is the key indicator of the health and safety of the population. In 2005, the mortality rate among young people aged 15–24 years was 5.4 deaths per 10 000 among males and 2.8 among females. The mortality rate among boys is double that of girls in the same age group.

Violent deaths, which include accidents, suicides and homicides, are the predominant causes of death in this age group. From a total of 587 registered cases of violent death in 2005, 23 in the age group 0–14 years and 28 among 15–19-year-olds were due to accidents. According to the State Statistical Office, there were 16 suicides committed by young people between 15 and 24 years in 2005, which is the lowest standardized suicide mortality rate in Europe (4.34 per 100 000). The number of registered homicides among young people of 15–19 years is increasing, from 8 registered in 1995 to 13 in 2005.

Some statistics on mortality rates among young people aged 15–24 years are shown in Table 2.

Table 2. Mortality rate per 10 000 young people aged 15–24 years by gender and cause of death, 1997–2005

| Cause of death | 1997 | | 2003 | | 2005 | |
|--|------------|------------|------------|------------|------------|------------|
| | Male | Female | Male | Female | Male | Female |
| Malignant disease | 0.9 | 1.0 | 0.9 | 0.4 | 0.7 | 0.4 |
| Violent deaths (accidents, suicide, homicide) | 3.1 | 0.8 | 3.7 | 0.8 | 2.8 | 0.8 |
| Respiratory diseases | 0.5 | 0.1 | / | / | 0.1 | / |
| Cardiovascular diseases | 0.6 | 0.5 | 0.6 | 0.06 | 0.8 | 0.4 |
| Undefined conditions | 1.3 | 0.4 | 1.0 | 0.4 | 0.7 | 0.4 |
| Other | 1.3 | 0.8 | 0.9 | 0.6 | 0.2 | 0.6 |
| Total | 7.7 | 3.7 | 7.3 | 3.1 | 5.4 | 2.8 |
| Source: State Statistical Office Processing: Republic Institute for Health Protection | | | | | | |

Morbidity

In the health care institutions that provide primary health care for school-aged children and youth, the largest proportion of registered diseases is acute respiratory diseases. Increases in morbidity from mental disorders, malignant disease, infectious diseases and injuries were found between 1999 and 2005. Alongside increased levels of physical abuse of adolescents and violence within the family, in schools and on the streets is now more frequently seen, although there are no data to support these observations.

Some statistics on morbidity rates among young people aged 15–19 years are shown in Table 3.

Table 3. Most prevalent causes of morbidity per 10 000 young people aged 15–19 years registered by health care services, 1999–2005

| Group of diseases and health problems | 1999 | 2003 | 2005 |
|--|----------------|----------------|----------------|
| Pregnancy and postnatal period | 0.8 | 7.2 | 3.6 |
| Injuries and poisoning | 269 | 253.9 | 307 |
| Mental disorders | 59 | 61 | 59.7 |
| Respiratory diseases (including acute cases) | 4 026.7 | 4 867.8 | 4 932.6 |
| Infectious diseases | 176.7 | 211.8 | 276.4 |
| Malignant disease | 7.5 | 11.7 | 10.3 |
| Total morbidity | 7 388.3 | 8 858.1 | 8 602.1 |
| Source: State Statistical Office Processing: Republic Institute for Health Protection | | | |

Accurate determination of the external cause of violent death is of essential importance in estimating risk factors to support measures to prevent violence and violent death. Adolescents comprise one third of self-injured hospitalized patients. Females at the age of 15–19 years are most likely to self-injure, while males of the same age group have the highest rate of hospital morbidity through intentionally caused injury by another individual.

Around 2% of children under 5-years-old in the former Yugoslav Republic of Macedonia are moderately underweight, and less than 0.5% are classified as severely underweight. Nine per cent of children have stunted growth or are too short for their age and 2% are too thin for their height (2).

Because of the dangers of increasing obesity in the future and the raised concerns about this public health problem throughout the EU, it is essential to collect appropriate data on the height and weight of adolescents and young people in the former Yugoslav Republic of Macedonia and to take appropriate health promotion

steps concerning their eating habits now, so as to avoid the consequences of obesity in the population as a whole.

Young people and their sexual and reproductive health

Data on sexual and reproductive health, like other data relevant to adolescents and young people, are not routinely collected as part of health statistics in the former Yugoslav Republic of Macedonia and are not sufficiently addressed in the collection of data on mortality and morbidity. A number of quantitative and qualitative behavioural studies relating to sexual and reproductive health have, however, been conducted in the country, and they indicate the following.

Knowledge, sexual norms and sexual behaviour

Young people (aged 15–24 years) have high levels of awareness and knowledge of HIV/AIDS and sexually transmitted infections (STIs). The level of HIV/AIDS knowledge among young people (42%) has remained practically unchanged since 2005 (when it was 40%), but knowledge among injecting drug users, sex workers and MSM has improved (3).

The majority of young people are sexually active, mostly with a regular partner. There has been a slight decrease in the percentage of young people (aged 15–24) who started sexual activity before the age of 15. Just over 14% of males said they had first sexual intercourse under the age of 15, with the equivalent for females being 4.4%. This means around 24 000 males and 7 000 females under the age of 15 are sexually active – a worrying statistic. Fifty per cent of adolescent males, compared to 25% of adolescent females, had their first sexual experience by the age of 17 years (3).

Most young men report having at least one non-regular partner in the last 12 months. Only 39% of males reported that they used a condom during their last sexual intercourse, with around 59% of them citing reduced sensitivity as the main reason for not using a condom (3).

Small numbers of young people engage in particularly high-risk sexual behaviour. These include the 12% of young men and 2% of young women who are involved in commercial sex and the 2.6% of young men having sex with other men, with almost half not using a condom at last sex (3).

Around 50% of high-school students lack information about contraceptives and have insufficient knowledge about contraceptive use. Less than 60 % of students believed contraceptive pills were efficacious and only one third agreed with the principle of dual protection. The prevalence of modern contraceptive use (excluding condoms) is extremely low, with only 1.6 % of young girls reporting using pills (4).

Fifty-six per cent of young girls have one or more friends or close relatives who have had abortions, but only 29% are familiar with the places where the abortion could be performed (4).

Teenage pregnancy is part of the reproductive behaviour of adolescents in the former Yugoslav Republic of Macedonia. In 2005, 7.8% of newborns were born to juvenile mothers (under the age of 19). The specific fertility rate in that year was 21.7 live births per 1000 women under 19 years (5). Even though there is a downward trend in the specific fertility rate in the age group 15–19 years (it was 45.6 per 1000 live births in 1994), the country still has a significantly higher rate than is found in EU countries (6).

The abortion rate among adolescents is an important indicator of the sexual and reproductive health of this population group, and the lack of this indicator renders reproductive health statistics incomplete. Official data on the national abortion rate are unreliable as they have mainly been taken from the state-owned health care institutions and are not disaggregated by age groups or other health determinants. In addition, due to privacy and confidentiality issues, large numbers of young girls decide to have their abortions in private clinics, meaning they remain unreported.

The incidence of STIs among adolescents and young people, as reported in data from the state-owned health care reporting system, does not give an accurate estimate of the extent of the problem. According to some sources, the former Yugoslav Republic of Macedonia is experiencing an increasing trend in STI incidence among youth, particularly in relation to Chlamydia, trichomonas and the human papillomavirus (HPV). Out of 111 registered HIV-positive cases, 19% are aged 20–29 years.

Sexual and reproductive health services for young people and adolescents and the policy environment

Sexual and reproductive health services available to young people

There are no specialized age- or gender-appropriate services at primary health care level focusing on the sexual and reproductive health of adolescents. Girls of over 14 years have the right to choose a gynaecologist in primary health care who provides health care services to all women in the reproductive period; there are no special services for adolescents. No services for sexual and reproductive health are provided for adolescent boys at primary health care level.

Preventive health care is provided in the form of systematic examinations, immunization, health education and counselling for children in and out of schools settings. These are provided by the so-called “preventive health teams” working within health care centres at municipal level. However, less attention is paid to sexual and reproductive health education and counselling due to school doctors lacking the skills, time and space necessary to address these issues properly. There is no specified number of classes related to the health and development of adolescents in the undergraduate medical curriculum and postgraduate specialization in school medicine has recently been terminated.

Youth-friendly service approaches do not form part of existing national adolescent and youth health programmes. Health services for adolescents and young people, including sexual and reproductive health services, are fragmented, specialized, use biomedical approaches in health service delivery and lack sound referral mechanisms between health, education and social services. The utilization rate of existing reproductive health services is very low: according to a United Nations Children’s Fund (UNICEF) report published in 2006, only 16.6% of female adolescents aged 13–19 years have visited a gynaecologist and almost half do so only once in their lives (7). This very low attendance rate leads to the conclusion that these services are neither attractive to, nor acceptable to, young clients.

Male adolescents in the same UNICEF study considered existing reproductive health services as not appropriate to their needs. Only 16.2% of male respondents aged 13–19 years could indicate which medical specialist was responsible for STI treatment. Just over 41% of male and 36.1% of female adolescents (aged 13–19 years) felt comfortable when visiting health facilities and more than half considered their health care workers to lack motivation in their daily work (7).

Most health care providers lack training in youth-friendly approaches, particularly in relation to practising counselling and communication skills, acknowledging the rights of all adolescents to service delivery and understanding adolescent and youth participation in the design, delivery and monitoring of youth-friendly services. This is explained by the existing policy and legislative environment regarding young people’s health and development in the former Yugoslav Republic of Macedonia, which is inconsistent and fragmented and does not recognize young people as a specific social category. National regulations spanning the social, health and education sectors are not integrated into a cross-sectoral youth policy and are not based on the principles of empowering young people to actively influence decision-making processes on issues that are relevant to their health and well-being.

In 2004, the International Planned Parenthood Federation (IPPF) knowledge, attitudes and practice (KAP) survey concluded that most of the problems are related to the demand of adolescents for sexual and reproductive health services than to actual provision of services. No adolescent or youth-only sessions are offered by sexual and reproductive health services or public health institutions in the former Yugoslav

Republic of Macedonia. However, the Ministry of Health, in partnership with relevant international organizations (IPPF, UNICEF, UNFPA and Partnership for Health) and the NGO HERA, has since 2005 been promoting the concept of youth-friendly health services as part of primary health care. As a result, two youth-friendly sexual and reproductive health centres, called “I want to know”, now operate in the capital city of Skopje.

These serve as “best practice” models for integrated health and social services within public health institutions countrywide, primarily focusing on promotion and provision of free and anonymized sexual and reproductive health services for mainstream and the most vulnerable young people, with an emphasis on Roma youth, street and institutionalized children, sex workers and young MSM.

NGOs, supported by the Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria (GFATM) project, are mainly involved in providing youth peer-education opportunities, outreach HIV-prevention services and testing for most-at-risk youth groups, including MSM, sex workers and injecting drug users. Existing harm-reduction programmes are being effectively implemented by local community-based NGOs. The GFATM project has increased the role and capacities of a large number of local and community-based NGOs in the last five years, especially those dealing with vulnerable young people, and has fostered collaboration between state health institutions and local NGOs, particularly in the field of HIV testing. There are still, however, no funds available to support NGOs’ activities within existing state health preventive programmes for young people and vulnerable groups; this presents a potential threat to the continued sustainability of numerous NGOs beyond the project life.

Specialist doctors in school medicine received UNICEF-supported training on new approaches to adolescent health and development in 2006/2007.

Health institutions involved in providing health care services for adolescents and youth, regardless of the level of health care provided, do not have specified quality standards and protocols for working with adolescents and young people on issues such as confidentiality, privacy, access to information and working hours adjusted to their needs.

Policy environment and regulatory framework

The government adopted the national strategy for child and adolescent health and development in February 2009. This positively addresses the sexual and reproductive health of young people and the need for youth-friendly services. The national HIV/AIDS strategy 2007–2011 and the national youth strategy also focus on preventive programmes and activities targeting young people, with an emphasis on the most-at-risks groups.

Most strategies detail action plans that accurately address the needs of young people in relation to HIV and sexual and reproductive health. But while the documents are in place, there is lack of government commitment to effective implementation and provision of adequate resources. Most strategies also lack monitoring and evaluation plans.

Ongoing reforms in primary health care and the privatization of gynaecological services have led to increases in costs for users of sexual and reproductive health services and the withdrawal of gynaecology services from the poorest areas in the country on economic grounds. For instance, there is no gynaecologist in the biggest Roma community in the former Yugoslav Republic of Macedonia, the municipality of Suto Orizari (30 000 inhabitants); Roma women have to travel around 5 km to the nearest gynaecological “cabinet”; although this is not a great distance, the cost of getting there and accessing the services impinges on the family budget, which acts as a disincentive to use the services.

The Law on Health Care and the Law on Health Insurance regulate public health issues. These state that the children of each insured person will be medically insured until 18 years of age. After this, they will remain insured (to their 26th birthday) only if they are enrolled in the formal education system. The former Yugoslav Republic of Macedonia has a high coverage of children and young people enrolled in the education system,

so most of the young population is medically insured through their parents' participation in mandatory health insurance.

No specific health legislation is in place, however, for adolescents and young people on issues such as access to contraception. The basic health insurance package does not contain specific clauses related to adolescents and young people; particular measures on age or vulnerability have to be specified in the policy to cover adolescents' and young people's access to services and drugs, including contraception.

The Law on Health Protection defines that young people up to the age of 18 can use health services only if accompanied by their parents or guardians. This presents barriers to the use by young people of many services, such as HIV/STI and reproductive health services, without parental escort. The law does not specify which services can be used by young people without an escort: for instance, it is not clear if young people up to the age of 18 can legally obtain sexuality counselling without parental consent or escort.

Confidentiality and privacy are ensured within the Law on Patients' Rights, but there is no specific law provision on the age at which a minor may have a medical procedure performed without parental or guardian consent. No confidentiality policies or guidelines are in place within health facilities.

"I want to know" model of youth-friendly services

Planning the initiative and initial implementation

It all started in 2004 with the IPPF Balkan project (2001–2005), which aimed to promote and enhance sexual and reproductive health in five former Yugoslavian countries. IPPF, as the initiator, with HERA and several other Balkan NGOs, started working on the concept of youth-friendly services. The idea was to increase access to high-quality integrated care for youth in the countries, followed by the opening of youth centres which would guarantee privacy and confidentiality and ensure that the environment was appropriate to, and welcoming of, young people.

HERA, IPPF and the Ministry of Health decided at that time to develop youth-friendly services as integrated parts of government primary health care clinics, but sustainability and financing from the state health system beyond the project life had to be ensured. HERA, in partnership with the Ministry of Health, therefore selected the biggest primary health care clinic in the former Yugoslav Republic of Macedonia, Health Home Skopje, as its partner in the development of youth-friendly services. The agreement between HERA and Health Home Skopje defined the equal responsibilities of each party in service delivery for young people in terms of the provision of reproductive health supplies, payment for service providers and technical assistance and maintenance.

A range of preparatory and training activities was put in place prior to the opening of the youth centre. These promoted increased skills and knowledge among service providers from the partner clinic and the staff/youth volunteers from HERA, who would be working together in the youth-friendly services model. The IPPF self-assessment manual on youth-friendly services enabled partners to design the programme and define the range of services provided by the youth clinic to appropriately address the needs of young people and to ensure a welcoming ambience.

Seventeen primary health care service providers with different medical and social science backgrounds, including gynaecologists, general practitioners, school doctors, psychologists and dermatologists, together with five peer educators and youth volunteers from HERA, were involved in the self-assessment of youth-friendly services, design of the action plan and renovation and refurbishment of the youth clinic.

HERA, as a youth NGO, has ensured youth participation and technically supports the development of youth-friendly services. Involvement of young people in the design of the youth-friendly service was crucial to further utilization of the centre's services by young people and to improved communication between youth clients and service providers.

The first youth centre was opened in April 2005 in basement premises in one of the dispensers of the Health Home Skopje, situated in the downtown area. It had a separate entrance from the other services in the health institution. HERA decided to use these premises as they provided an accessible location with a segregated entrance, ensuring maximum protection for the client’s privacy.

Several promotional activities followed, aiming to ensure the visibility of the centre and promote sexual and reproductive health and the rights-based approach. There were two youth events, including a youth photographic exhibition and a two-day film festival (Fig. 1). Information, education and communication (IEC) materials were developed and peer-education activities were conducted in the centre, schools and social institutions and with NGOs dealing with vulnerable youth.



Fig. 1 Promotional posters for youth photographic exhibition (left) and film festival (right)

The young people of HERA were the power and the brains behind these creative activities. To ensure that young people continue to be active players in service provision, the peer-education workshops have become part of the services provided in the centre. “I want to know”, the name of the centre, was chosen by HERA’s young volunteers; it suggests that young people have both the needs and the right to know about their sexuality and sexual and reproductive health. HERA’s youth volunteers also developed the centre’s logo of the heart in the shape of an apple to symbolize how love and health are essential to the well-being of young people (Fig. 2).



Fig. 2 Logo of the youth-friendly centre “I want to know” at Health Home Skopje, the former Yugoslav Republic of Macedonia

The centre’s initial target was young people in schools and those living in social care institutions. A series of seminars with high school teachers and social institution employers in Skopje was organized to promote the centre’s services and further facilitate contact with young people in schools.

The multisectoral team of service providers from primary health care enables the youth centre to provide a wide range of free and anonymized services and to serve as a youth clinic for sexual and reproductive health. Free provision of medicines (including drugs to combat STI), contraceptive pills, intrauterine devices (IUDs)

and condoms is available. Contraceptives and STI drugs are donated by international donors and partners who support the youth centre (including IPPF, the Open Society Institute (OSI) and Norwegian Church Aid (NCA)) and the Ministry of Health through the GFATM.

Services currently provided by the youth centre include:

- routine gynaecological check-ups
- sexuality counselling
- STI and contraception counselling
- Pap smear test
- STI tests (gonorrhoea, Chlamydia, HPV, Trichomonas, HIV)
- pregnancy tests
- ultrasound examinations
- free STI therapy
- free modern contraception (pills, IUDs and condoms)
- skin care services
- peer-education workshops, in and out of the centre premises
- informal lectures on adolescent health, emphasizing SRH, in and outside the centre
- counselling for parents
- access to advice and counselling by telephone for those reluctant to visit the centre
- referrals to other government clinics and NGOs providing SRH services, including social services.

UNICEF and the United States Agency for International Development (USAID) also approached HERA and IPPF to offer support to their promotional and peer-education activities.

Reaching the most vulnerable

From the beginning, HERA’s main concern has been about how young people who are most vulnerable and marginalized and who have the greatest needs for HIV and SRH services, especially sex workers, injecting drug users and the MSM population, could access the centre and use its services. HERA decided to develop a strategy to ensure coordinated cooperation with NGOs dealing with vulnerable youth and guarantee that the confidentiality and rights of these young people will be respected.

This was not an easy task, as most service providers were not familiar with the lifestyles of the young people and lacked appropriate information; there were also residual prejudices and stereotypical assumptions. HERA therefore organized awareness-raising and rights-based training for service providers on MSM, sex workers and injecting drug users, ensuring the active involvement of representatives of the target populations. HERA continued to work with the service providers after the training events, trying as much as possible to emphasize the issues of confidentiality and privacy of the youth clients, especially for those who are most vulnerable (Fig. 3).

Fig. 3 Clients’ rights poster



HERA has also signed a memorandum of understanding with two NGOs who deal with vulnerable youth to ensure the highest standards of confidentiality and privacy of their clients. Consequently, after six months in operation, HERA's youth centre made provision for services to vulnerable groups outside the mainstream youth population, enabling access to services even to those who are most at risk of contracting HIV/STI and having an unwanted pregnancy.

Expanding the initiative

In order to respond to the sexual and reproductive health needs of Roma young people, especially to Roma girls and women in reproductive age, and as prioritized in the national Roma health decade strategy, HERA initiated the opening of another youth-friendly service with their partner clinic, Health Home Skopje.

There are some characteristics regarding the health of the Roma community that are significant within the general national overview of health. These principally arise as a result of various cross-cutting issues faced by the Roma people:

- bad socioeconomic circumstances;
- substandard living conditions;
- inadequate social insurance provision;
- lack of primary health protection (there is a small number of ambulances with insufficient medical staff in Roma communities);
- a weaker focus on preventive health measures (there is no great parental demand for immunization of children and systematic examinations of children and women are performed only on an irregular basis);
- a low level of health education among the Roma population;
- expensive health services and medicines; and
- the specific attitudes and traditions of the Roma people, who often seek cures in traditional medicine and marry early (often to someone with a significant age difference), and who lack information on their health rights.

In August 2006, with financial and technical support from UNICEF, Partnership in Health and IPPF, the second "I want to know" youth centre was opened in the biggest Roma community in the country (Suto Orizari) (Fig. 4). The Roma youth centre is located in the facilities of the primary health clinic of the municipality. The model of the first youth centre has been replicated, with the centre being integrated with primary health care services, but having separate facilities for young people, ensuring clients' privacy.



Fig. 4 Roma youth centre "I want to know": promotion for youth event, 2006

The team of service providers work at primary care level, provide services in the Suto Orizari and Cair ambulance, and form outreach preventive teams. The team includes a gynaecologist and school doctors and ensures a multisectoral approach to dealing with the SRH of young people and providing quality and accessible services. The creation of the centre meant that for the first time, this range of services was available to Roma youth.

Services providers were chosen from those already working in the Roma municipality, who were familiar with the traditional and cultural characteristics of the Roma people and who had experience in providing them with services. Extra training on dealing with most-at-risk groups and addressing issues of confidentiality and privacy was provided. HERA has also engaged a social worker to provide social care and referral services for young Roma people, especially for Roma women who are vulnerable to domestic and gender-based violence and sexual abuse. HERA has reported many cases of domestic violence among Roma women since the centre opened and has developed a strong referral system with local authorities, social centres and the police to deal with such cases.

Mainstream HERA youth volunteers were involved in the design of the programme from the start, working with the team of service providers in the centre. No Roma youth volunteers were available at that time, but HERA started to organize activities to attract young Roma people and ensure Roma youth participation in the centre, such as peer-education training and youth musical events. Collaboration was established with more than 10 Roma grassroots NGOs to promote the youth centre and ensure better utilization of its services. Currently, HERA has four Roma peer educators who are actively involved in the centre through outreach work and organizing peer-education workshops.

Because of the poverty and unresolved citizenship and health insurance status of the Roma people, HERA decided to expand the age limit for centre clients to 35 years for Roma women. This enables it to respond to the reproductive health needs of the poorest people and to those who do not possess health insurance or who are recipients of state social aid. The same model has been replicated as a means to attract the most-at-risk groups, especially MSM and sex workers, to the Health Home Skopje centre. The Ministry of Health has now signed an agreement with NGOs dealing with vulnerable groups – Equality for Gays and Lesbians (EGAL) and Healthy Options Project Skopje (HOPS) – to further guarantee the privacy and confidentiality of clients and target groups.

The number of donors interested in supporting the Roma youth centre's programme and services has increased over the last three years, with the inclusion of organizations such as UNFPA, OSI and NCA. HERA has also received additional support from the GFATM project in terms of provision of STI therapy, contraception and test kits for HIV and syphilis, ensuring a link with HIV services and its youth sexual and reproductive health clinics.

Lessons learnt

Both youth centres have provided a wide range of high-quality, youth-oriented services to young people over the last four years. They have separate facilities and entrances that enable the young people to feel welcome and guarantee privacy and confidentiality. Around 15 service providers with different medical backgrounds are part of the youth centres' teams, and they possess the knowledge and skills on adolescent SRH and development to ensure a professional, multisectoral approach to service delivery is pursued.

The centres have registered more than 10 000 visits, with 50% new clients each succeeding year. They ensure that a significant percentage of those receiving services come from marginalized and vulnerable groups: in 2008, 94% of the young people who received services belonged to these groups. Well-established collaboration with NGOs dealing with vulnerable groups, schools and social institutions and the wide range of services on offer are viewed as being essential to the success of the centres and the high utilization of services from key populations they have seen.

What really makes the "I want to know" service such a successful story is the active involvement of young people at all stages of the centres' development. The young people are continuously involved in the design of the youth centres' programmes, in developing promotional activities and acting as part of the team of health workers providing peer education within and outside the centre setting. They are also included in the process of evaluation of services through informal communication with their peers and performing client exit interviews, a practice that is in place in both youth centres.

Some statistics from the centres are shown in Table 4.

Table 4. Youth centres' statistics

| Indicator | 2005 | 2006 ¹ | 2007 | 2008 | Total/average |
|--|--------------------|--------------------|----------------|-------|------------------------|
| Number of visits | 1 262 | 3 393 | 3 086 | 2 998 | 10 739 |
| Percentage of first visits | | 73% | 34% | 46.2% | 51%² |
| Number of SRH services | 1 380 | 9 225 | 9 568 | 6 685 | 26 858 |
| Percentage of attendees from vulnerable groups | Data not collected | Data not collected | 72% | 94.2% | 83.1% |
| Gonorrhoea (diagnosed cases) | 0 | 2 | 2 | 5 | 9 |
| Chlamydia | 0 | 73 | 8 ³ | 2 | 83 |
| Trichomoniasis | 9 | 54 | 70 | 5 | 129 |
| HIV | 0 | 0 | 0 | 1 | 1 |
| Clients' satisfaction (percentage) | 97.2% | 95.5% | 94.45% | 93.5% | 95.1% |

¹The large increase in the number of visits in 2006 is due to the opening of the second “I want to know” centre

²Average percentage of first visits over the period 2006–2008

³Chlamydia tests have not been provided by the youth centres since 2007, when health services reforms ended their free-of-charge status

Source: service statistics: youth centres for sexual and reproductive health “I want to know”, 2005–2008

We have learnt that no matter how many services are provided at the centres, all the needs of young people cannot always be fulfilled. The referral system is therefore reviewed on a continuous basis.

The existence of youth centres changes young people's habits and lifestyles. We have noticed more and more young people coming for contraception and sexuality counselling in recent years, whereas at the beginning most young people came to get their sexuality problems sorted. Improved Internet coverage in the country has ensured an increased number of visitors to our web site, www.sakamdaznam.org.mk. Young people can easily access the site to ask for information or advice on SRH.

The youth centres have established quality management systems for clients and service provision recording and evaluation. Electronic client files, observation forms and checklists and the client's satisfaction form are used as evaluation tools to ensure high quality of service provision and protection of clients' confidentiality. Since all the services that are provided to young people are based on client anonymity, the centres do not report STI cases to the Institute for Public Health, the responsible institution for compiling national health statistics, as the client's full personal data, including full name and address, are required when submitting STI reports; submitting data to the institute would therefore not conform with the youth centres' policy and the agreement between HERA and the partner clinic.

The IPPF guidelines on SRH service delivery and peer education serve as standards and protocols for high-quality service provision in the field of SRH. Each year, HERA and its partner clinic organize self-assessment workshops on youth-friendly services to discuss achievements and identify gaps in complying with the core principles of the centres. This has resulted in the development of an action plan for 2009. The involvement of all – young people, clients and service providers – in the evaluation of the youth-friendly services allows us to get a better overall picture of the youth centres, enabling the services to continue to meet the needs of the young people and to remain accessible.

Conclusions

Political will

The “I want to know” youth centres can serve as “best practice” models for integrated health and social services within public health institutions, primarily focusing on promotion of sexual and reproductive health and reaching out to the most vulnerable young people. These kinds of preventive services for adolescents and young people should be scaled-up and expanded countrywide, following the development of protocols and standards to guide their work.

Although the “I want to know” model meets most of the WHO standards on youth-friendly services, government and Ministry of Health commitment to ensuring funds for the youth centres within the public health care system is still lacking. This presents the most serious barrier to their sustainability.

The youth centres have built the institutional and operational capacities of the partner clinic Health Home Skopje over the last four years to enable them to integrate existing youth-friendly services within the public health sector. However, all HERA’s and its partner clinic’s advocacy and direct lobbying efforts with key stakeholders have not resulted in increased financial support for the established youth centres. The Ministry of Health has continuously expressed its support for the “I want to know” idea and is seen as a promoter of the services, so it can be concluded that lack of activity in this area is down to a greater focus from government and key stakeholders on efforts to reform health policies than on lack of funds.

Seizing the opportunities of health care reforms

Despite this, the youth centres are still operating. They are mostly financed through foreign donor projects and are supported by the partner clinic, which provides premises and service providers such as school doctors, psychologists and nurses.

One of the major concerns in terms of their sustainability, however, is the reform of primary health care which started in 2007. Gynaecology and general practitioner services in primary care have been privatized, which has meant increased fees for some service providers in the youth centres, especially gynaecologists. As the health reforms are moving towards the introduction of a family doctor system in 2020, it is obvious that some adolescent SRH services will be provided by family doctors, not gynaecologists, whose numbers in primary care settings are expected to decrease. This will mean services such as sexuality counselling, Pap smears and STI testing will be carried out by family doctors.

The new reforms have also resulted in a decreased number of medical services being provided in the centres, as young girl clients are now obliged to select their general practitioners for SRH services that are covered by health insurance, such as Pap smears and Chlamydia tests, rather than seeing a gynaecologist in the youth centre. At present, the health reforms mean that the partner clinic has no legal obligation to maintain gynaecologists in the youth centre, and additional funding for the youth centre from the Ministry of Health does not appear as part of the policies; further, youth-friendly health services did not become a part of the mandatory health insurance scheme.

The privatization of primary health care has further increased the cost of HERA’s contribution to running the centres. As privatization progresses, the partner clinic is placing the youth centres further down its agenda as the financial benefits become less easy to identify and their long-term sustainability, in the absence of government or health insurance funding, becomes increasingly in doubt. The changes in the health provision “pyramid” will demand new approaches to better address the SRH of young people and ensure the reforms do not influence accessibility to services.

Moving towards a mixed model: dedicated clinics and youth-friendly primary care

Reforms in the health system and the process of decentralization are demanding change in strategic interventions and the development of new approaches to expanding the model of youth-friendly services and their integration with primary health care. Today, the national prevention programme for prevention of HIV/AIDS and national programme for mother and child health protection are seen as potential sources of advocacy for the inclusion of youth clinics (and other initiatives on the development of youth-friendly services) within public health system financing. The health legislation does not recognize young people as a specific social category in terms of their vulnerability, so there are concerns that this issue will not be comprehensively addressed unless a specific adolescent/young people health preventive programme is introduced in government health programmes and budgets.

Establishing specific youth centres is a good model for effectively addressing the needs of young people for SRH services, as it enables the provision of separate facilities exclusively for young people and guarantees their privacy and confidentiality. This is a preferable model to simply building service providers' capacity in youth sexual and reproductive health, and addresses the needs of young people in a way that is gender-sensitive and youth-aware through outreach programmes.

The model is also crucial for improving the quality of, and access to, health care in existing health services for young people, if specific programmes are in place and appropriate funds are available. Health clinics have to be officially certified as adolescent and youth friendly in primary health care, so the development of necessary standards and protocols for existing health services is seen as essential in achieving major improvements in service delivery.

Making evidence-based decisions a reality

In the absence of relevant and appropriate national data on sexual and reproductive health, there is an obvious need to strengthen health information systems to continuously and adequately monitor the health status of adolescents in the country. A lack of relevant data on the health condition of adolescents and youth, including new threats to their health resulting from changed conditions in their social environment, hinders the identification of future priorities in creating public health interventions. It is therefore recommended that the highest priority be given to the regular collection of a minimum data set on which to manage the future planning of appropriate SRH services for this age group.

Creating a supportive policy and regulatory environment

As there is no specific national health legislation in place for adolescents and youth, it is recommended that a specific legislative framework for the rights of adolescents and young people in terms of their sexual and reproductive health, which includes access to information and services, be developed. This should reflect best-practice models from other EU countries. Specific health legislation for young people and their SRH could specify particular conditions, such as the need for young people to have easy access to services, including STI testing and contraception, that are of low cost and high quality.

Working in partnership

The NGO sector plays a role in the development of youth-friendly services. It is obvious that health clinics which provide services for adolescents and young people lack the motivation and skills necessary to involve young people in all stages of making their services friendly. There are many youth NGOs that can serve as valuable sources for recruiting young people to be involved in the design of SRH services and to take an active role in service provision and establishing links between health professionals and youth.

It is recommended that health clinics take into consideration the IPPF manual on self-assessment of youth-friendly services as a basis from which to assess current service provision for young people and develop

an action plan. It is important to ensure that NGOs and young people take part in the assessment, and that their comments and ideas are acknowledged. Young people are the strength of a society, and their needs and views have to be respected and valued.

Acknowledgments

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References

1. News release no:2, 1.9.08. Skopje, State Statistical Office, 2009.
2. *Child poverty study in FYR Macedonia*. Skopje, UNICEF, 2007.
3. *Bio-behavioural study conducted among young people and most-at-risk populations for HIV in the former Yugoslav Republic of Macedonia*. Skopje, Ministry of Health and Republic Institute for Health Protection, 2008.
4. *Access of high school students to sexual and reproductive health services in four capital cities of the Balkans: a cross-sectional survey*. Ghent, International Centre for Reproductive Health, 2005.
5. *Information on the health status of mother and children in the Republic of Macedonia, 2005*. Skopje, National Institute for Mother and Child Health Care, 2006.
6. *A league table of teenage births in rich nations. Innocenti report card No. 3, July 2001*. Florence, Innocenti Research Centre, 2001.
7. *Assessment of youth-friendly services in the former Yugoslav Republic of Macedonia*. Skopje, UNICEF, 2006.

Ukraine: development of youth-friendly health services

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Executive summary

Ukraine is the second biggest country in Europe and has a population of 46 143 000. Teenagers comprise 27.5% of all children in the country (aged 0–17 years). The social importance of youth health is determined by the fact that adolescents represent the reproductive, intellectual, economic, social, political and cultural potential of the country.

According to the Law of Ukraine on Childhood Protection (No. 2402-III of 26 April 2001), passed by the Supreme Council of Ukraine, a child is a person aged under 18 years, and the Law of Ukraine on Supporting Social Formation and Development of Ukrainian Youth (No. 2558-III of 21 June 2001) defines youth as citizens of Ukraine aged 14–35 years.

Incidence and rates of primary morbidity among adolescents are, like those for the general population and children, still growing. The morbidity rate among those aged 15–17 increased by 18% and incidence by 17% between 2003 and 2008. The main cause of morbidity among adolescents was respiratory pathologies (50.2%), with injuries and intoxication at 6.4% and skin diseases at 7.4%. Mental health and behavioural disorders are almost twice as common among males as females.

Road accidents are the leading cause of death among Ukrainian young people (40%), a fact that has attracted significant interest from society in general and the industrial sector. The number of registered HIV-positive people aged 25–49 reached 63.8% in 2008. The *Most at risk adolescents: the evidence base for strengthening HIV response in Ukraine (I)* study carried out in 2008 by the United Nations Children's Fund (UNICEF) showed that one third of adolescents who are injecting drug users (IDUs) use injecting drugs daily, and another third use them several times a week. Over 15% of street adolescents have experience in using injecting drugs.

For a number of reasons, there was recognition in the late 1990s of a need to change approaches to youth health care. Reasons included: progressive youth health impairment; insufficient resources for youth care; limited accessibility to health services for adolescents; social influences on youth health development; and insufficiently trained staff in youth health services.

Cooperation between UNICEF and the Ukrainian Government started in 1997 and the youth-friendly clinic (YFC) pilot project was launched in 1998, with the first clinic opening in Kiev.

Youth-friendly clinics then began to be established in different regions of Ukraine, with UNICEF support: there are currently 53 such clinics running successfully, 14 of which have been created with UNICEF support. This review covers the entire 10-year experience of YFC development in Ukraine.

Introduction

Ukraine is the second biggest country in Europe (after the European part of the Russian Federation). It covers 603 628 km², which makes up 5.7% of the territory of Europe and 0.44% of the world. The population of Ukraine (according to the State Committee of Statistics of Ukraine) consisted of 46 143 000 people in 2008, of which adolescents constituted 27.5% of all children (aged 0–17 years). Out of 1 824 526 adolescents, 935 153 (51.3%) were males and 889 443 (48.7%) females; 626 265 (34.3%) of adolescents lived in rural areas, which is approximately half the number living in urban areas (1 198 331 (65.7%)).

According to the Law of Ukraine on Childhood Protection No. 2402-III of 26 April 2001, passed by the Supreme Council of Ukraine, a child is a person aged under 18 years, and the Law of Ukraine on Support of Social Formation and Development of Ukrainian Youth No. 2558-III of 21 June 2001 defines youth as citizens of Ukraine aged 14–35 years.

The social importance of youth health is determined by the fact that adolescents represent the reproductive, intellectual, economic, social, political and cultural potential of the country. The adolescents of today are children who were born in difficult times during the early 1990s and who live in a period of rapid spread of HIV/AIDS, tuberculosis and other public health hazards. The collapse of the Soviet Union and the institution of newly independent states, including Ukraine, and subsequent democratic changes have led to the emergence of market economies, changing the socioeconomic environment. This has affected children's health and socialization and has increased levels of family dysfunction, with a rise in the number of families in crisis.

Major health and development problems of adolescents in Ukraine

Primary morbidity among adolescents

Primary morbidity means *diseases diagnosed for the first time in life* during a year, and the spread of diseases implies *all diseases among the population* happening within a year, including acute and chronic, and new and previously known.

Incidence and rates of primary morbidity among adolescents are, like those for the general population and children, still growing. The morbidity rate among children aged 15–17 increased by 18% and incidence by 17% between 2003 and 2008. The main cause of morbidity among adolescents was respiratory pathologies (50.2%), with injuries and intoxication at 6.4% and skin diseases at 7.4% (Fig. 1).

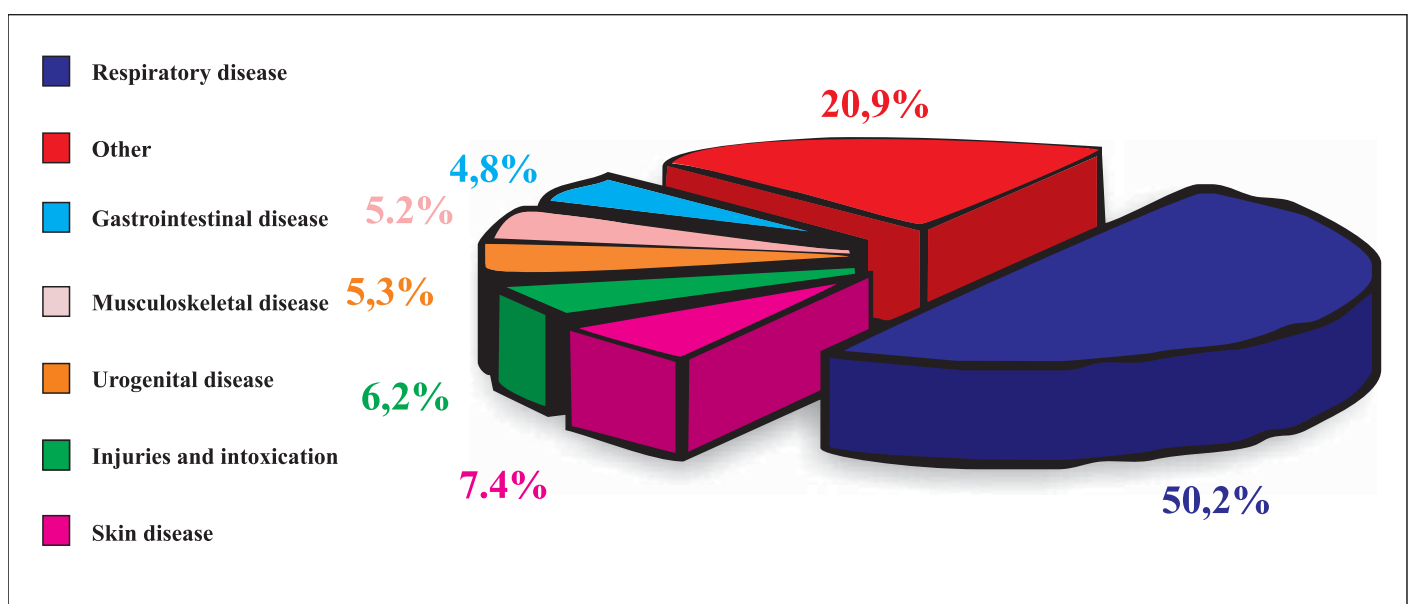


Fig 1. Morbidity among adolescents, Ukraine, 2008

Source: data from the Centre of Medical Statistics of the Ministry of Health of Ukraine

The lower morbidity rate found among rural children does not reflect the reality of their health conditions and is generally determined by poor access to health services due to:

- low parental awareness of health issues and, correspondingly, low motivation to access health services;
- the poor financial situation of rural families; and
- limited availability of health services in rural areas.

General morbidity rates are 18% higher among females than among males, but mental health and behavioural disorders are almost twice as high among males.

Mortality among adolescents

A total of 1024 adolescents died in Ukraine in 2008 (Fig. 2).

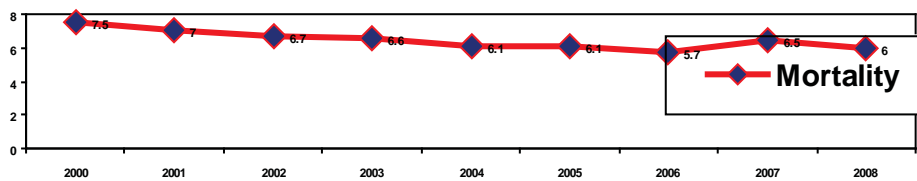


Fig. 2 Mortality rate among adolescents, Ukraine, 2000–2008 (per 10 000)

Source: data from the Centre of Medical Statistics of the Ministry of Health of Ukraine

Despite the downward trend in the mortality rate among adolescents, which decreased by 9% between 2003 and 2008, adolescent mortality in rural areas is almost 1.5 times higher than in urban (Fig. 3).

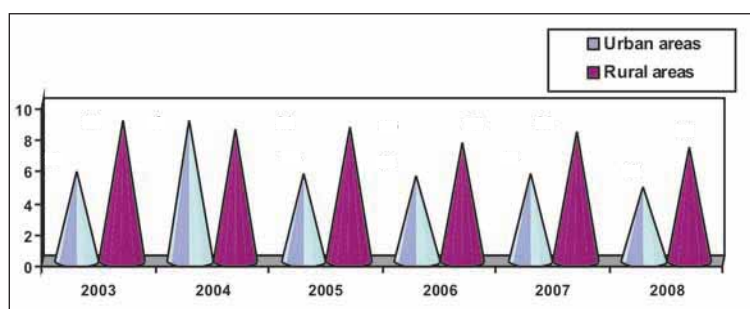


Fig. 3 Comparative analysis of mortality rates among rural and urban adolescents, 2003–2008 (per 10 000)

Source: data from the Centre of Medical Statistics of the Ministry of Health of Ukraine

A similar tendency is observed in the mortality rate caused by external factors among rural adolescents, which is almost 1.5 times higher than that in urban adolescents. Road accidents are the leading cause of death (40%), which means this is an important issue for society in general and for the industrial sector.

Major health problems related to risky behaviour

Adolescents and the HIV/AIDS epidemic in Ukraine

According to the last coordinated assessment by local specialists and foreign experts (the Ukrainian AIDS Prevention Centre of the Ministry of Health, WHO, the United Nations Joint Programme on HIV/AIDS (UNAIDS) and the International HIV/AIDS Alliance in Ukraine), almost 440 000 people of all ages in Ukraine were HIV positive at the end of 2007, including 395 300 people aged 15–49 years. HIV-positive people in Ukraine constitute 1.63% of the population aged 15–49.

Data on age distribution of HIV-positive people provided by the Ukrainian AIDS Prevention Centre of the Ministry of Health show that in 2005, people aged 25–49 years made up 61.9% of all registered HIV-positive people, and that this figure reached 63.8% in 2008. The National Programme on Prevention, Treatment, Care and Support for People Living with HIV/AIDS for 2004–2008 was launched in 2004. Data analysis from the programme showed that 17.9% of all registered HIV-positive people in 2005 were aged 15–24, and that this had reduced to 13.2% by 2008.

The proportion of parenterally transmitted HIV infection (mainly through drug injection) in overall HIV infection transmission rates continues to reduce, while the proportion apportioned to sexually transmitted infection (STI) is increasing. In 2008, parenterally transmitted HIV represented 37% of new cases, while sexually (mainly heterosexually) transmitted infection constituted 41.9%.

HIV infection in Ukraine is concentrated in the most-at-risk groups. UNICEF carried out the *Most at risk adolescents: the evidence base for strengthening HIV response in Ukraine* study (1) in 2008. It showed that one third of adolescents who are IDUs use injecting drugs daily, and another third use them several times a week. Drug injection has become habitual among such adolescents, with 15.5% of street adolescents having experience of using injecting drugs.

Adolescents and young people are at the centre of the HIV/AIDS epidemic in Ukraine. Data from the Oleksandr Yaremenko Institute for Sociological Research in 2006 (2) show that the number of new cases of HIV infection among IDUs aged 15–19 almost tripled, making up 32.3% of the total number of HIV-positive people. Reasons for the increase in new cases of HIV infection among IDUs include lack of knowledge about HIV transmission and the attitudes and behaviours of adolescents, which makes them vulnerable to HIV/AIDS. As a result, Ukraine has seen the age of the first use of injecting drugs going down to 13–15 years, with regular use established by age 17, and 10–20% of commercial sex workers in Ukraine being under 18 years.

The main reasons behind the HIV/AIDS epidemic, including the epidemic among adolescents, are:

- the spread of drug and alcohol addiction;
- increased numbers of socially maladapted people and insufficient measures to control this phenomenon;
- insufficient financial resources allocated to national programmes because of the difficult socioeconomic situation faced by the country;
- the influence of media in promoting crime, violence and immorality; and
- lack of national policies and strategies for outreach and awareness-raising in HIV/AIDS prevention activities.

According to a study carried out in 2007 as part of an international project involving WHO and the Oleksandr Yaremenko Institute for Sociological Research which looked at students in schools, vocational schools (VS) and higher education institutions (HEIs) (3), 2% of females have their first sexual experience at the age of 13 or 14, 10% in year 10 at school, 30% when in VS and 18% when at HEIs (Fig. 4).

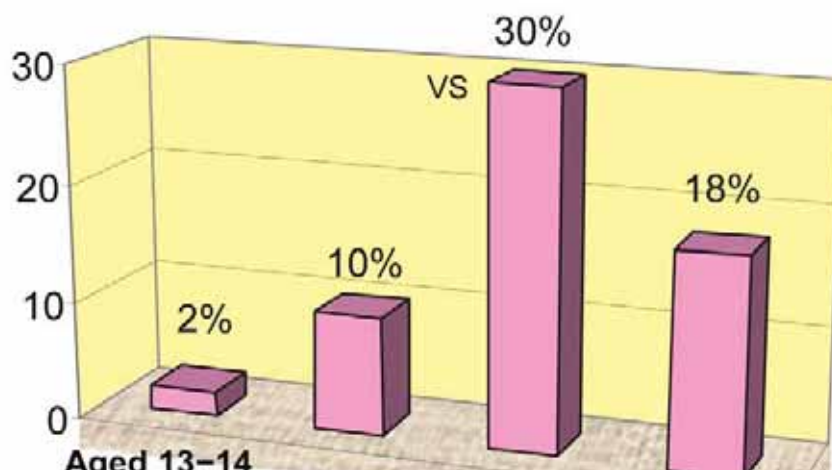


Fig. 4 The age of sexual initiation of females (3)

Reproductive health of adolescents

Disordered menstrual function Reproductive health is one of the aspects of youth health that influences young people’s life chances, and the rate of disordered menstrual function among females aged 15–17 is growing.

Unintended pregnancy and abortions among adolescents Within the last decade, the abortion rate among girls under 14 decreased by half, and went down by 3.5 times among girls aged 15–17. In absolute figures, the number of abortions among female adolescents aged 15–17 in 2008 was 3576. Against this background, the number of childbirths increased in 2008: one female adolescent out of every 1000 gives birth to a child, meaning there are 9777 babies born to adolescent mothers yearly.

Sexually transmitted infections (STIs) Despite the fact that syphilis and gonorrhoea incidence has decreased by half during the last five years, the rate is 3.2 times higher among females than males. Cases of STIs suggest that adolescents have insufficient knowledge of contraception and do not carry out safe sex practices. According to the most-recent Health Behaviour in School-aged Children (HBSC) survey carried out in Ukraine (4):

- 20% of year 10 students aged 15–16, 30% of first-year students at HEIs, about 45% of first-year students at vocational schools and over 10% of year 8 students aged 13–14 have had sexual experience;
- 25% of respondents aged 13–14 and 20% of those aged 15–16 had had sexual intercourse without using condoms; this included year 8 girls (aged 13–14) (50%) and first-year students of VS and HEIs (aged 17–18) (about 40%); and
- one in three adolescents was under the influence of alcohol or other substances during their last sexual intercourse.

Adolescents and use of substances and injecting drugs

Based on data from the Ministry of Health, 347 adolescents aged 15–17, including those suffering from mental health and behavioural disorders as a result of substance misuse (103 adolescents), are receiving treatment, care and observation from detoxification institutions in Ukraine. It should be stressed that only those who have accessed health services are registered in these figures, and that they account for only 20% of the total number of adolescents experiencing problems with alcohol, drugs and other substances. The HBSC survey showed that:

- depending on the age of the respondents and the type of education institution, around 45–85% of adolescents aged 11–16 have consumed alcoholic beverages, 30–75% have smoked tobacco products and 10–25% of those aged 13–16 have used substances;
- 20–25% of males had their first smoking experience at the age of 11 or even earlier, while 15–20% of females had this experience at the age of 14 and 10–20% at the age of 15; and
- 15–35% of males and 5–25% of females consumed alcohol for the first time at the age of 11, while 10–25% of females did so at the age of 14.

The survey also showed that around 60% of parents (and 40% of mothers) knew little (or did not know anything) about the way their children spent their time after school and in the evening.

The context of the health care system and health services accessible to young people

Health care system financing

The health care system plays a crucial role in ensuring decent lives for the population, including adolescents and young people. The system is mainly financed from the central budget with a mandatory health insurance component for separate categories of the population making up 0.6%. The Ministry of Health has been issuing licenses for private medical practice for many years, and the private medical sector has both inpatient and outpatient facilities providing primary and clinical health care. However, the private sector is not sufficiently developed to build the capacity of medical institutions in providing youth-friendly health services (YFHS), but it is hoped that the private sector will expand its activity in providing YFHS in the future.

Models of youth services and staff

Currently, youth services are regulated by the Ministry of Health and provided by paediatricians, paediatric care specialists, physicians for young people and family doctors/general practitioners. Many children's clinics still have departments for young people where health care specialists trained in adolescent medicine practise.

The essence of working with young people, including vulnerable groups, lies in early detection of pathologies through routine examinations. The shortage of qualified staff and limited time allocated to consultations within outpatient clinics do not allow for the provision of necessary counselling on reproductive health, HIV/AIDS prevention and other issues.

Young people and adolescents are often embarrassed to visit clinics because their parents, peers or teachers might find out. They can be ashamed to ask questions about reproductive health, teenage pregnancy, HIV/AIDS or STIs. There is a shortage of youth health workers and, unfortunately, they are not always adequately prepared for having honest and open discussions with adolescents.

Before 1991, the resource base of youth services consisted only of physicians for young people. By 2008, only 537 such physicians worked at 715 outpatient clinics. Their work is mainly focused on preparing young men for military service and bureaucratic procedures. Before the Ukrainian Law on Childhood Protection was passed in 2002, young people received health services from adult specialists: since 2002, with the formal recognition of a child being someone who is under 18 years, adolescents have been referred to paediatric services. Reform of the youth health care system generated the need to create specialized health services specifically targeted on this age group, reflecting the fact that they are "no longer children, but not yet adults".

The family planning system developed in Ukraine in compliance with international standards has become one of the most effective mechanisms for preserving reproductive function of young people and, indeed, the entire population in reproductive age. The system is one of the most recent subsystems to appear within the national health care system, being developed in 1995 when the national family planning programme was officially adopted. There is now a network of family planning centres and offices in Ukraine, with family planning and reproductive health centres functioning in each region. Each women's counselling centre has a family planning and reproductive health office that welcomes not only adult women and men, but also adolescents. Family planning centres prescribe contraceptives individually, according to the WHO criteria, provide full information on all kinds of contraception and offer advice on contraception appropriate to individuals' age, health condition and reproductive plans.

Healthy lifestyles are promoted within the school health care system, but the main responsibilities of nurses and school doctors are about ensuring good sanitary conditions, conducting routine medical examinations and performing immunizations. Healthy lifestyle promotion is didactic in nature and is based on outdated models that do not take into account the individual needs of students, their personal priorities and the development of life skills. The school health care system is now being revised by the Ministry of Health to meet the needs of modern students more effectively.

Regulatory framework

Within the Ukrainian health care system, health services (diagnosis, prevention and treatment) can be provided to children under 14 years only with the consent of their parents, and after 14 with the consent of the adolescent and their parents.

The Civil Code of Ukraine (Ukrainian Law No. 435-IV of 16 January 2003) stipulates that a person who has reached the age of 14 has the right to choose a doctor and receive treatments recommended by him or her. The same standard is stated in the Fundamentals of Health Legislation of Ukraine (Ukrainian Law No. 2801-

XII of 19 November 1992). Obviously, “to choose a doctor” includes choice of the institution where the doctor works and the doctor’s specialization, gender, age and experience.

According to the current Fundamentals of Health Legislation of Ukraine, children under 14 (including those between 10 and 14 years) cannot undergo a medical examination independently. They can do it only at the request of, or with the consent of, their legal representatives, who have the right to be present at such examinations.

Referral of adolescents to paediatric services and excessive workloads of primary care specialists have had an impact on further system reforms and stimulated the development of new services. It was recognized in the late 1990s that there was an urgent need to adopt new approaches to youth health care in Ukraine because of:

- progressive youth health impairment;
- insufficient resources for youth care;
- limited availability of health services to adolescents;
- social influences on youth health development; and
- insufficiently trained staff responsible for providing youth health services to adolescents during independent visits or on referral by social services.

Development of youth-friendly health services

Initiation

Providing youth health care within adult services did not allow the basic needs of young people for information on reproductive health and prevention of STIs to be met. As a result of the cooperation between UNICEF and the Ukrainian Government that started in 1997, and reflecting the desire to introduce modern approaches to youth health services, the youth-friendly clinic (YFC) pilot project was launched in 1998. The first of these clinics was opened in Kiev to provide youth-friendly services to local adolescents and young people.

The events preceding the creation of the first YFC, its organization and the need for further establishment of the network, as well as reform of the paediatric health service, stimulated further active implementation of youth-friendly services, training for specialists and the creation of the required regulatory and procedural framework.

The 2008 YFC activity analysis showed that these clinics have an important role in HIV/AIDS prevention and the development of responsible health behaviours among adolescents and young people.

Organizational structure and funding

Ukrainian YFCs are structural subdivisions of regional, city and district hospitals, clinics and social centres for families, children and young people: they are therefore part of health facilities financed from local and regional budgets. To ensure systematic funding of YFCs at local and regional levels, it is necessary to support regional, city and district authorities to understand the importance of, and need for, developing a network of such clinics.

Today, many health units are involved in providing youth health services, with 53 YFCs already in existence within the structure of such health facilities. They are found in:

- 21 health facilities for children
- 10 health facilities for adults (including student clinics)
- 15 central district hospitals
- 4 social centres for families, children and young people
- 3 office networks (Sevastopol, Ternopil and Uman in the Cherkassy region).

The last of these, the “office network”, offers a useful example of how YFCs can work with different health facilities. These offices are located within different health facilities (family planning centre, dermatovenereologic dispensary, AIDS prevention centre and a detoxification clinic). Network activity is coordinated by the senior paediatrician of the city or region and regulated as part of health facilities through an order on city health management structures. Cooperation agreements are signed with social services and nongovernmental organizations (NGOs) that work with youth and adolescents.

Although YFCs are structural subdivisions of health facilities, they differ significantly from other health facilities in providing psychological and social assistance in addition to health services and having a primary focus of HIV prevention. The concept of the “youth-friendly approach” implies not only a benevolent and respectful attitude towards adolescents, but also the deployment of health and social workers specially trained to maintain reproductive health, to prevent HIV/AIDS, and to support the development of responsible health behaviours among adolescents and young people.

Currently, major problems include limited funds being allocated to these facilities and lack of equipment, medicines and supplies. Budgets do not include financing for education activities or for the acquisition of contraceptives and condoms. Traditional delays in financing at the beginning of the year, inconsistent supply of funds within the financial year and rigid regulation of expenditure and capitalization also present challenges.

Under these circumstances, international technical assistance provides significant support and stimulus for implementation of youth-friendly health services in the majority of regions. It is especially important to attract funding and to establish closer cooperation with social services for families, children and young people, NGOs and community-based organizations in relation to educational activities and financial support for supplies such as single-use syringes, gloves and condoms.

Most problems can be solved and risks reduced by implementing integrated policies in different sectors, especially through close cooperation between health and social services. Their activity has to be aimed at developing systems to allow adolescents to access counselling, health and psychological assistance, in addition to information on health issues.

Target group and service package

Sixty-nine per cent of YFC clients are children and teenagers aged 10–18 years, and 4.8% are young people under 24. The main target audience, however, continues to be teenagers aged 14–18: they face particular challenges, such as lacking the ability to independently access services, being economically and psychologically dependent on parents (they do not always have money to pay for regular treatment and do not want to tell their parents about the existing problem), lack of trust in adults, and lack of responsible health behaviours. Apart from teenagers and young people, parents, relatives, guardians and youth specialists are also clients of YFCs, and they too can access counselling from YFC specialists in relation to dealing with their child’s or client’s issues.

Some of the main YFC objectives set out in the Ministry of Health Order on Improvement of Youth Health Care of 2 June 2009 are:

- developing responsible behaviour towards all personal health components (physical, mental, social, and spiritual), paying special attention to the issues of reproductive health through developing knowledge, skills and practice of responsible behaviour;
- preventing risky behaviours and reducing the impact of its consequences (prevention or cessation of unhealthy habits, such as smoking and alcohol and drug use);
- preventing STIs, including HIV;
- maintaining reproductive health and preparing for parenthood; and

- developing responsible behaviour in teenagers and young people with regard to interpersonal and sexual relations.

However, YFCs are not an alternative to, and must not be a substitute for, already existing youth services, such as children's clinics. They have to complement each other to achieve the common goal of nurturing healthy youth.

Young people need services that differ from those designed for adults. Teenagers often do not consider themselves to be "ill" and mostly access health services for other reasons. This is why YFCs are targeting both treatment and other health aspects, such as:

- addictive behaviour as a result of substance use and smoking;
- sexual behaviour, early sexual initiation, unintended pregnancy, early motherhood, STI and HIV;
- malnutrition;
- depression and suicidal behaviour; and
- accidents and injuries.

YFCs are especially useful for teenagers at risk of HIV infection as a result of their behaviour. Prevention activities with these groups of teenagers are extremely important to counteract the HIV epidemic. Teenagers at risk find it more difficult to access prevention and harm-reduction services because the majority of existing programmes are designed for adults. Today, YFCs are institutions that target not only pupils, students and employed young people, but also children's home and orphanage inmates, HIV-infected young people, unemployed youth and youth not enrolled in school, street children, commercial sex workers, men having sex with men (MSM) and other categories of teenagers and young people. This is an important aspect of YFC activity, since the YFC may be the only institution open to voluntary visits from these clients.

Staff training and the multidisciplinary approach

Continuous training of all staff members is an integral part of team-building. Apart from attending advanced training courses in their field of specialization and in youth health care, all specialists have to be trained in providing youth-friendly health services. They can also access training in social approaches to health care, teamwork, targeted services, specialized youth services, outreach work, counselling and communication skills.

One of the cornerstones of quality health services is the multidisciplinary approach, which requires joint effort from different specialists to solve the problems of the client. Responsibility for professional training of multidisciplinary team (MDT) members working in YFCs rests with management. The MDT is guided by the main principles of providing support to YFC clients: voluntariness, benevolence, accessibility, confidentiality, anonymity and adopting a non-judgemental approach. The MDT consists of a medical specialist, a nurse and a social worker. If necessary, other specialists such as a family doctor, a psychologist, a psychiatrist or a lawyer can be involved.

A training programme for specialists was held in 2005, from which 16 received national trainer certificates. Since 2006, trainers have held workshops on youth-friendly approaches for specialists in various fields of youth health services (physicians, psychologists, social workers and nurses). With the support of UNICEF, the training programme has been extended year on year. Consequently, workshops on HIV counselling and testing for YFC specialists have been held since 2008 and a new training course has been developed for YFC psychologists and social workers. Over 420 specialists have received training over the last three years.

It is also necessary to involve family health specialists in YFC activities, and they were provided with training in spring 2009. A new course on youth-friendly health services introduced at Kharkov Medical Academy of Postgraduate Education in 2008 marked an important achievement in YFC network development in Ukraine; this course has been taken on by other postgraduate medical institutions since the beginning of 2009.

Regulatory framework development

YFC network development is supported by organizational and methodological activities. During 2008, a guide to providing youth-friendly health services and a number of regulatory documents for YFC activities were developed. In addition, the “Time frame for youth health services” and guidelines for assessment of youth health care centres (departments and offices) to ensure compliance with the status of “youth-friendly clinic” (using WHO guidelines) were approved by the Ministry of Health (5).

There are currently favourable conditions for the development of the YFC network in Ukraine. A regulatory framework has been created and the Methodological and Organizational Centre of the National Specialized Children’s Hospital has been successfully operating since 2007, monitoring the work of existing YFCs and contributing to the creation and further development of YFCs in all regions of Ukraine.

YFC activities are regulated by the following main orders.

- Joint orders:
 - the Order of the Ministry of Health and the Ministry of Family, Youth and Sports of 30 March 2005, No. 1/135 on Approval of Youth-friendly Health Services Development Activities for 2005–2010;
 - the Order of the Ministry of Health and the Ministry of Family, Youth and Sports of 17 April 2006, No. 1209/228 on Approval of the Order of Cooperation Between Social Centres for Families, Children and Youth with Children and Youth Health and Social Services.
- Orders of the Ministry of Health of Ukraine:
 - 12 October 2004, No. 465 on Improvement of Adolescent Health Care;
 - 19 August 2005, No. 415 on Improvement of HIV Voluntary Counselling and Testing;
 - 2 June 2009, No. 383 on Improvement of Children and Youth Health Services (according to this order, “Health centre/section for children and young people “youth-friendly clinic” (hereinafter YFC) provides health services to teenagers and young people based on a friendly approach to young people and operates as a section for teenagers, the main principles of which are voluntariness, benevolence, accessibility, anonymity and non-judgement to the visitor”;
 - 2 June 2009, No. 382 on Approval of Time Frame for Providing Youth Health Services.

Community connection and youth involvement

The active participation of YFC specialists in different social prevention activities, programmes and projects based on cooperation agreements is an important aspect of prevention work with teenagers and young people. That is why YFC specialists are engaged in:

- prevention activities (actions, programmes, etc.);
- the development of information and teaching materials on health issues such as STIs, HIV infection and unintended pregnancy (these include the production of cards, posters and video materials);
- psychological counselling for teenagers and young people;
- mobile stations;
- running a hotline.

The development of responsible health behaviour implies interactive learning at training workshops with active participation of teenagers and young people.

All clinics work in close connection with social services. In some clinics, the worker of the social centre for families, children and young people is engaged in client counselling. According to young people, this contributes to creating an informal atmosphere and helps young people who have come to the clinic to feel

more comfortable. There are also YFCs in which the social worker provides social support and counselling to families with maladapted children and carries out prevention activities, sometimes in partnership with the psychologist. The social worker is part of the YFC multidisciplinary team.

Experience of cooperating with parents is also growing, with parents receiving counselling on social adaptation of teenagers, and training is being provided for volunteer teams who support YFC staff in carrying out information and educational activities.

Cooperation with different youth organizations has a special role in the development of YFCs. This increases the effectiveness of the clinic's work, gives staff an opportunity to learn about new and interesting youth activities and improves the quality of services provided. State organizations in social, health, family planning, AIDS prevention and control, crisis and rehabilitation centres are mainly involved. Many clinics also cooperate with NGOs that support YFC publicity campaigns and educational activities.

Cooperation with the media allows YFCs to extend their educational activities and increase their profile. For instance, constantly enhancing the profile of the work of specialists in YFCs (youth physicians, social workers, psychologists and educators) significantly extends the circle of specialists interested in the work of the clinic.

Some clinics opt to specialize in particular health fields and devote their energy and resources to developing services in those areas. An example would be a clinic that specializes in psychological and psychotherapeutic activities. Apart from a paediatrician, gynaecologist and urologist, this clinic would also have several psychotherapists and a psychologist. Clients who attend the clinic would have an opportunity to access integrated psychological and psychotherapeutic services (diagnosis, psychological and family counselling, and individual and family psychotherapy).

The process of youth participation in different prevention activities contributes to the development of responsible health behaviours. The notion of "health" is quite abstract for them, and it is hard to expect that 15–18-year-olds with little life experience are going to adopt responsible health behaviours straight away. By getting young people to participate in YFC activities, the organizer engages young people as a resource in carrying out the prevention activities organized by the clinic and also contributes to youth training and information-gaining. Getting involved in YFC activities allows young people to develop active health behaviours and to learn the skill of sharing information with their peers effectively. Youth involvement in clinic activities allows for more effective implementation of the principles of the youth-friendly approach and provides for a quality connection with this target group.

Monitoring, evaluation and standardized approach to quality assessment

Much experience has been gained within YFC work in Ukraine in recent years which has helped to shape the clinics' development and enhance service quality. According to information obtained from YFCs over their first 10 years, there is a need to assess the need for clinic creation and the satisfaction of those who use them. Accordingly, the analytical centre of the community-based organization "Socioconsulting" carried out a survey of clients and staff of YFCs in the summer of 2008 (6). This work was commissioned by UNICEF and constituted an evaluation of YFCs.

The aim of the work was to analyse YFC services from the viewpoint of their accessibility, appropriateness, ability to match the needs of teenagers and young people in response to the HIV/AIDS/STIs epidemic and in relation to reproductive health, relevance, efficiency, effectiveness, potential sustainability and the need for YFC network extension. Collection of qualitative empirical data was performed with the help of inclusive and stimulating monitoring during the planned visits to YFCs of 51 teenagers and young people and informal interviews with clinic management and staff and officers representing the key national partners (30 in total). The findings of the survey were as follows.

- Within the last three years, the international practice of creating services that provide health care and information support based on the youth-friendly approach has been implemented in Ukraine. A network of 53 YFCs had been created by the beginning of 2009 (growing from 28 in 2006).
- Ukraine is now collecting more and more quantitative information about YFC services, including indicators of regional coverage with youth-friendly services, number of clients and consultations provided, scope of individual and group work on HIV/AIDS/STIs prevention, and reproductive health services.
- The YFC network has been developing under favourable policy and legislative conditions, and there is a regulatory framework for YFC development.
- YFC network development has been accompanied by active methodological activities. A guide on providing youth-friendly health services was produced in 2008 (5).
- Since 2005, joint training for health care staff and specialists from social centres for families, children and young people has regularly been carried out with the support of UNICEF. The training is run by 12 specially prepared national trainers.
- The range of services provided by YFCs depends mainly on the model on which they work. Most YFCs are coordinated by health care bodies and are run as divisions of health care institutions (offices, departments, centres, etc.) that provide health services such as counselling, diagnosis and treatment of the consequences of risky behaviours, as well as prevention of STIs and HIV/AIDS. YFCs opened within social centres for families, children and young people are run as consultation offices. Their main activity is usually focused on primary (individual and group) prevention of STIs and HIV/AIDS.
- Ukrainian young people have a high demand for free consultations from specialists in sexual and reproductive health (77%), including HIV prevention (28%), HIV testing (21%) and STI diagnosis and treatment (18%).

All surveyed YFCs generally adhere to the principles of the youth-friendly approach in providing health services to teenagers and young people. Survey investigations into the implementation of youth-friendly principles in 18 clinics gave the following results.

- The YFCs give young people an increased opportunity to receive services through simplified access, working hours that are responsive to the needs of young people, and provision of complex services that are provided free of charge.
- All surveyed clinics are placed in accessible locations, are simple to access, offer low-priced or free services, have working hours that are convenient to young people, provide integrated care, enable clients to access any information they need, and prepare and distribute information materials.
- Efforts are made to promote the voluntary, conscious access of teenagers and young people to services through informing, involving and motivating them. All surveyed YFCs sought to create appropriate conditions that would encourage voluntary, conscious access of young people to clinics and their services.
- Youth service provision is based on understanding and acceptance of the age-specific characteristics of the target group, tolerance, respect, confidentiality, support for the expression of young people's own ideas and non-judgement of service users. All clients of the above-mentioned clinics had "a feeling that they were a welcome 'guest' at the YFC" and a sense of satisfaction that their problems were handled with understanding and respect.

It is also worth highlighting the other principles of the youth-friendly approach, without which effective work of clinics is impossible.

- **Confidentiality** allows the client to trust the specialist and talk to him or her about anything, knowing that this information will stay within the room. Confidentiality matters even more since HIV voluntary counselling and testing have become part of YFC services.
- **Anonymity** is also very important for teenagers and young people. Clients of the clinic are not identified, to eliminate the possible use of medical certificates against their interests. The teenager

does not have to provide his or her identity data and address when arranging to attend the clinic. At the first visit, the registration officer explains how the record is drawn up in detail. If a young person wants to retain anonymity, his or her identity data and address are not recorded. The registration officer has to explain to the client what confidentiality and anonymity mean. As a rule, confidentiality is sufficient, since no one has the right to read the record apart from clinic specialists. The visitors of all clinics in the survey were assured of the anonymity and confidentiality of their visit.

- **Non-judgement** of the client is especially important in working with young people. The study findings showed that clinic clients were satisfied that their problems were handled with understanding, respect and in a non-judgemental way.

This study showed that no health care institutions could satisfy the need of teenagers for support if they did not have a youth-friendly attitude, offer accessible health care and provide the possibility of voluntary access. In the light of an obvious lack of institutions responding to the health needs of young people and teenagers and contributing to youth health care and HIV/STI prevention in Ukraine, significant efforts have to be made to build the capacity of existing YFCs and create new ones.

In 2008/2009, new impetus was given to efforts to improve the quality of youth health through the Ministry of Health Order of 2 June 2009, No. 382 on Approval of Time Frame for Providing Youth Health Services. This set out the criteria for effective activity and development of clinics and the time frame, criteria and indicators for providing youth health services within youth health centres (departments and offices). The criteria for effective YFC activity in compliance with this order are:

- compliance of YFC activity with its objectives and principles;
- staff assessment, with compliance with the position, possession of corresponding knowledge and skills and advanced training in the field, in youth health care and in providing youth-friendly health services; and
- assessment of the quality of youth-friendly health services in HIV prevention (the quality and volume of services, user satisfaction, etc.).

Standards for providing youth health services within institutions complying with YFC status include:

- compliance of the internal policy with the principles of youth-friendly services
- staffing and regular staff training in the youth-friendly approach
- confidentiality and anonymity
- prevention activity
- general health care
- social support and social services
- integrated services
- youth involvement
- monitoring and assessment.

The system of YFC monitoring and assessment should not depend on the subjective assessment of experts based only on statistics that do not always provide reliable information about service quality. YFC clients – teenagers and young people – have to be involved in planning, carrying out, monitoring and quality assuring YFC activities. Monitoring and assessment can be both internal, when they are performed by YFC specialists, and external, when they are performed by external experts.

An assessment of youth health centres'/departments' compliance with the above-mentioned criteria and standards will be launched in autumn 2009. This is being supported by the contribution of working group participants and international experts, including WHO staff.

Lessons learnt and recommendations

Analysing progress in recent years, we can confirm that the establishment of YFCs in most of the Ukrainian regions has been a significant step forward in contributing to youth health care and HIV prevention.

The staff of the majority of YFCs are enthusiastic, caring people with expertise in adolescent health. They are professional and tolerant and are guided by principles of confidentiality and anonymity. Their non-judgemental attitude allows them to understand the problems of teenagers better and to boost the trust of the latter in health care providers.

The number of visits speaks for the friendly environment in the clinics, as adolescents are likely to attend when they are not scared of talking to any staff member about their concerns. They come to such clinics with pleasure and often bring their friends along. They pass on information about the clinic and consultation process and tell peers that staff “won’t judge you and will understand you”.

The main factor taken into account in the creation of a YFC has been staffing with specialists who had expertise in the needs of young people and who had worked with them before. This is still relevant in the establishment of new YFCs. Training in the youth-friendly approach is the key element in the organization of such clinics. Working at YFCs implies that the staff have communication skills and an interest in working with adolescents. Such specialists usually want to work with adolescents due to their professional attitudes and personal principles, but staff motivation is still an issue.

It remains difficult to allocate staff hours within health care facilities, and gaining management understanding of, and support for, the need to create youth-friendly clinics is sometimes quite challenging. The experience of YFCs shows that clinics supported by the administration of district, city or regional health care institutions are more effective in terms of quality and the provision of integrated health services. And the more successful these clinics are, the greater the need for a wider network of such institutions throughout Ukraine becomes.

When a YFC is created, the most important issue is identifying what target group of adolescents and young people would be able to access services, taking into account the capacities of the institution. For instance, a clinic can provide access, support and referral to identified groups such as victims of violence, street children, drug users or people living with HIV. Unfortunately, there is still work to be done on reaching vulnerable groups such as these.

The following main problems have been identified during the first 10 years of functioning of the clinics in Ukraine.

- There is difficulty with the time allocated for consultations. The fact that a specialist has less than the optimal 30 minutes at his or her disposal to attend a client impinges on the quality of the consultation. The most important matter in a consultation is to help young people realize the risks of their own behaviour and to advise them on how to reduce or overcome the risk, and this aim is compromised with limited time allocation.
- The issue of providing free special examinations for clients is still a problem for many clinics. Cooperation with health care institutions such as dermatovenereologic dispensaries, AIDS prevention and control centres, infectious and other specialized hospitals and private clinics is not sufficiently strong yet.
- Many YFCs cannot provide their clients with free condoms, and there is no information about where young people can access them.
- Unfortunately, the problem of service accessibility to the groups of teenagers and young people who need these services most (mostly rural youth) remains. These groups also include street children, drug users and commercial sex workers. Sporadic evidence and experience of implementing targeted projects for female sex workers and MSM as part of YFC services is emerging, but extension of cooperation with social centres for families, children and young people and NGOs that can perform

outreach activities with these target groups is required.

- There is often an issue of insufficient awareness among the target group about the YFCs and services they provide. Their goals and location have to be promoted at schools, colleges, clubs, health centres and in other places visited by young people.
- The issue of consultations and educational activities with relatives, caregivers and, especially, parents of teenagers is still rather complicated. Some YFC heads do not share the concept of working closely with these groups.
- Insufficient funding for prevention activities is an issue within health care. There is evidence that investment in prevention activities is several times more effective than investment in treatment. The priority health issues for YFCs, which include reproductive health, HIV infection, STIs and drug addiction, require targeted prevention activities. Sufficient funding for prevention activity is therefore an essential prerequisite for quality youth health services.
- And, of course, insufficient staffing is an ongoing problem. The existing YFC staffing model is based on distribution of existing health care staff without allocation of additional human resources. This issue requires urgent consideration at legislative level.

In conclusion, YFC activities depend on:

- increased effectiveness in informing teenagers and young people about services provided by YFCs, for which it is possible to use different methods, including the implementation of active communication strategies and the creation of YFC web sites; and
- the need to mobilize business sector resources and to cooperate with NGOs in realizing financial potential.

All the Ministry of Health's organizational and methodological activities to support the establishment of YFCs aim to achieve:

- the extension of the YFC network throughout the entire territory of Ukraine;
- reduced general morbidity among adolescents;
- reduced HIV/AIDS and STIs morbidity; and
- the development of healthy lifestyles and responsible behaviours among teenagers and young people.

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References

1. *Most at risk adolescents: the evidence base for strengthening HIV response in Ukraine*. Kiev, UNICEF, 2008 (http://www.unicef.org/ukraine/media_10509.html, accessed 14 December 2009).
2. Балакирева ОН, Левин РЯ, Сосидко ТИ. Опыт реализации проекта "Профилактика ВИЧ/СПИДа среди молодежи (2003–2005)". Киев, Украинский институт социальных исследований, 2006.
3. Балакирева ОН, Рингач НО, Левин РЯ и др. Здоровье и поведенческие ориентации ученической молодежи Украины. Киев, 2007.
4. Currie C et al., eds. *Inequalities in young people's health. Health behaviour in school-aged children: international report from the 2005/2006 survey*. Copenhagen, WHO Regional Office for Europe, 2008 (Health policy for children and adolescents No. 5; http://www.euro.who.int/databibliography/Publications/Catalogue/20080616_1, accessed 20 July 2009).
5. Оказание медико-социальных услуг детям и молодежи на основе «дружественного подхода». Методические рекомендации. МЗ Украины при поддержке ЮНИСЕФ. Киев
6. Оценка клиник, дружественных к молодежи. Отчет Аналитического центра «Социоконсалтинг». Киев, 2008.

United Kingdom (England): getting health services right for young people

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Executive summary

In United Kingdom (England), considerable progress has been made in recent years in getting health services and support structures right for children, young people and their families, particularly the most vulnerable. Early intervention and prevention services underpin the approach to tackling incipient problems and breaking the intergenerational cycle of health inequalities. The public health agenda for children and young people aims to nurture healthy physical and mental growth and development and to reduce illness and mortality, both in the present and among the adults of the future.

Young people in England are healthier today than they have ever been and advances in medicine and technology, as well as social and economic developments, give most children and young people a healthier start than any previous generation has enjoyed. Support for parents, children and young people in promoting health and well-being has greatly improved and better provision is now made for children and young people with additional health needs. There is an enhanced focus on health and well-being in schools and further education settings and young people are offered more choice about where and how to access health care.

Having the right people, with the right skills, in the right place, at the right time is the ambitious target of recent initiatives. Achieving this will depend upon workforce development (via improved education and training for the wide range of professionals working with young people, from doctors and nurses to youth workers) alongside service improvement and reconfiguration, in particular by improving the environment within which services are delivered. The groundbreaking *You're welcome* quality criteria now being rolled out across England will help to ensure that all health services aimed at adolescents are young-person friendly. Children's trusts, the Healthy Child programme, the national Healthy Schools programme and the emerging Health Further Education Framework will all help clarify the role of a range of partners in promoting the health and well-being of young people in England, regardless of setting.

Significant public health challenges remain, from ongoing concerns about poor mental and emotional health and risk-taking behaviours to the increasing public and professional anxiety about the alarming recent increase in obesity and overweight. Governments and practitioners cannot change or improve health behaviours without the involvement and engagement of children, young people and their parents. Getting services right for users, and so encouraging young people's autonomy and self-determination in respect of lifestyle choices, will create a strong foundation upon which the health of the young nation can flourish.

Background

“Good health in the teenage years is inextricably linked to a young person's ability to fulfil their potential” (1).

In a challenging and rapidly changing world, nurturing the health and well-being of children and young people – from conception through childhood and adolescence – is a social and moral imperative. Ill health and impaired development in childhood and adolescence has many immediate and long-term effects upon individuals, their families and wider society. Poor physical, emotional and social development can result in a life-cycle of disadvantage, exacerbating inequalities, the effects of which will be felt for generations to come.

A wide range of recent and forthcoming national policy documents and strategies in England recognize the importance of getting services and support structures right for children, young people and their families, particularly the most vulnerable. The need to make health programmes and health services more “teen-centred” was the particular focus of the chief medical officer's annual report in 2008, and there is a cross-governmental commitment to making England the best place for children and young people to grow up in by 2020 (2).

The recently published 5–19 Healthy Child programme, building on that published for 0–5-year-olds in 2008, offers an unparalleled opportunity to bring together and put into practice the core strands of policy and evidence-based interventions to improve the lives of children and young people.

The economic and sociodemographic context

Young people in England are healthier today than at any time in the past. Medical, technological, social and economic advances have given many children and young people a healthier start to life than would have been possible in previous times. There is more support for parents, children and young people in promoting health and well-being and in meeting additional health needs. There is a greater focus on health and well-being in schools and colleges and more choice over how to access health care. Young people make significant contributions to their communities: 53% of young people aged 16–19 years have volunteered with a club or organization at least once in the last 12 months, while 78% have given unpaid help on an informal basis (3).

There are approximately 7.8 million young people aged 10–19 living in the United Kingdom. Together, children and young people make up roughly a third of the population. A broad range of ethnic groups is represented: minority ethnic groups make up around 10% of the population, with particular concentrations in urban areas. Those from minority ethnic groups tend to be younger: for example, over 30% of those from Bangladeshi groups and around 45% of those who are of mixed ethnic group are under the age of 16 (4).

Although young people in the United Kingdom do not experience the levels of poverty that are a feature of many countries (the country is more affluent than other European nations), there are wide variations between the circumstances in which they grow up and the opportunities they face. These variations can have significant implications for their current and future health and well-being.

Compared to other European countries, the United Kingdom has higher numbers of children and young people living in disadvantaged families. It is estimated that about 3.6 million children in the United Kingdom live in poverty (5). A family’s socioeconomic status is one of the most important determinants of the health of children: the lower the socioeconomic status of a household, the higher the risk for children of childhood mortality and long-term and acute illness (6). Although the proportion has decreased over the last decade, around 1.8 million children live in workless households. A quarter of all children are living in a household headed by a lone parent (4). In this regard, the United Kingdom compares very unfavourably with many similar countries (Fig. 1).

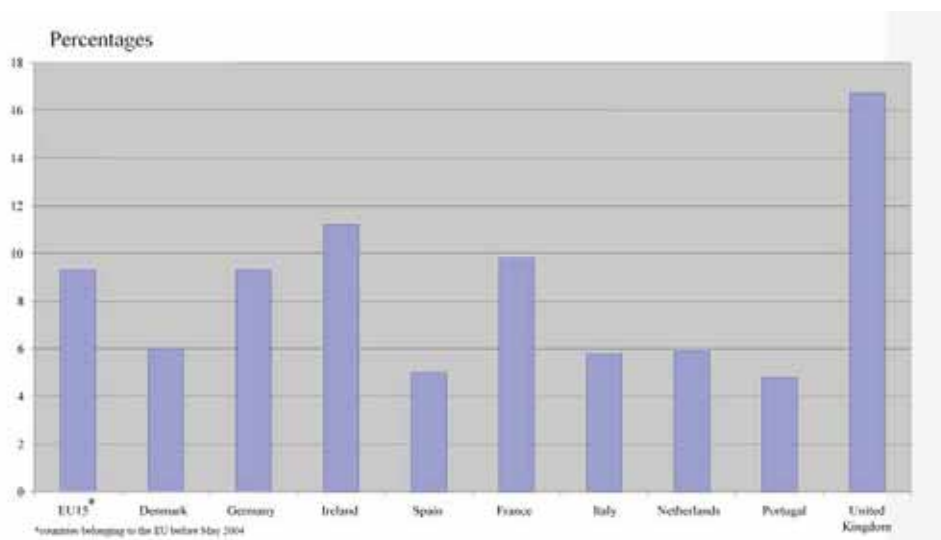


Fig. 1 Proportion of children aged 0–17 living in workless households in European countries, 2007
 Source: Eurostat, general and regional statistics, data sets 2008

A significant percentage of low-income families are headed by a lone parent. Lone-parent families are much more likely to be living in poverty compared to those with married or cohabiting parents. The increase in numbers of lone-parent households reflects much higher rates of births outside of marriage over the past 20 years.

Divorce rates have remained reasonably stable over the last 20 years. Increased rates of conceptions and births to teenagers have been portrayed as a major factor contributing to the increase in lone-parent households. Although teen conception rates are high across the United Kingdom compared to many other European nations, the rate among young women aged under 18 years in England has declined significantly since the start of this decade (Fig. 2). Teenage conceptions remain significantly more common among those from lower socioeconomic groups, those living in disadvantaged areas, those with low education attainment, and those who have had contact with the criminal justice system or spent time in the public care system.

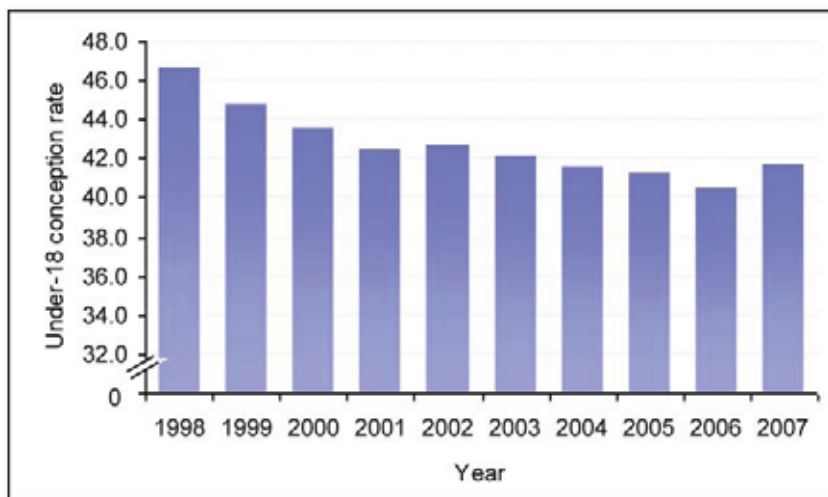


Fig. 2 Under-18 conception rate for England: 1998–2007
Source: Office for National Statistics and Teenage Pregnancy Unit, 2009
Rate per thousand females aged 15–17 2007 data are provisional

Young people are tending to stay in the parental home for longer (often because of unaffordable accommodation costs or the increasingly difficult employment situation) and receive greater financial assistance to, for example, pursue higher education. While this is the norm for many young people, too high a proportion of young people in the United Kingdom leave school at or before the legal school leaving age. This may be, for example, due to disengagement with education, or having their own caring responsibilities. Again, young people in the public care system, of whom there are around 60 000 at any point, fare worse here. Such young people are more likely to drop out of school without gaining qualifications, and to be in contact with the police.

The complexities of modern life and lifestyles present young people with significant challenges. Family structures and support, so important to development, have changed dramatically over recent decades. Today's children and young people often have to manage a complex web of relationships with multiple carers and stepfamilies, while the traditional family, in which knowledge and wisdom is shared across generations, is in decline.

Research indicates that children and young people in the United Kingdom spend more time in the company of peers and less time with adults and parents than young people in culturally similar countries (7). A recent report, however, indicates that parents are spending more time with their teenagers and are more likely to monitor their children's whereabouts than parents in the 1980s (8). Support and advice from other sources is therefore increasingly significant, although government rhetoric and legislation recognizes – and seeks to better support – the role of parents and carers.

In conclusion, although the relative economic position of the United Kingdom would suggest it should provide a favourable environment for young people to grow up in, there is huge variability between the 200

experiences and opportunities open to them. These economic and social inequalities translate too frequently into “health inequalities” in which some young people, such as those from ethnic minorities, young carers or young people in public care, experience poorer health as well as poorer health care. Early intervention plays a pivotal role in breaking the intergenerational cycle of health inequalities. Childhood problems can be strong predictors of poor and costly adult outcomes and problems left too long without intervention may never be tackled effectively (9).

The priority health and development needs of young people in England

The public health agenda for children and young people aims, by early and sustained interventions and support, to nurture healthy physical and mental growth and development and to reduce illness and mortality, both now and among adults of the future.

Centred on the needs of child and family, and working in partnership with them from the outset, this agenda seeks to empower children and young people as they mature and gain self-knowledge and greater autonomy to take increasing control over their lives, their choices and their well-being. It is therefore crucial that young people feel confident and comfortable accessing services intended to meet their needs, so encouraging their growing independence and autonomy.

Mortality in childhood in the United Kingdom is rare and continually fell during the latter half of the 20th century. Fig. 3 shows standard mortality rates from 1960 to 2000 in England and Wales (10).

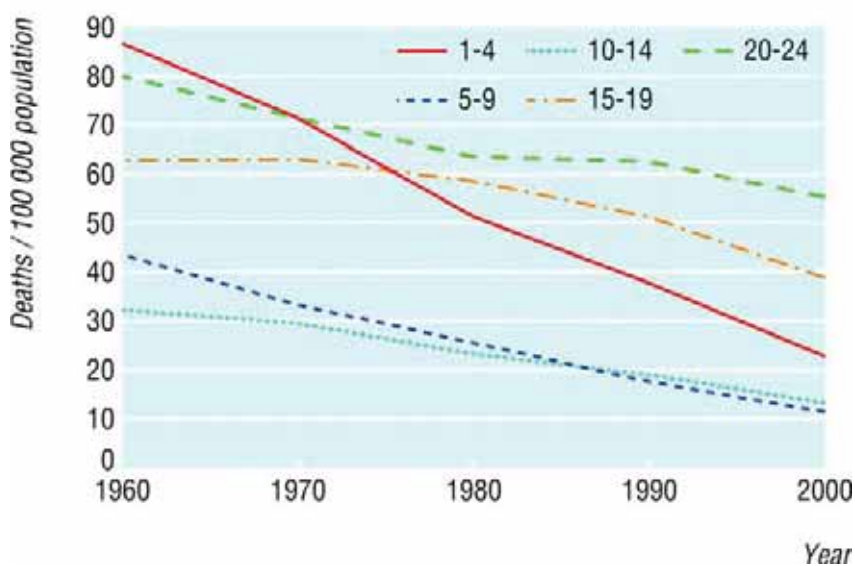


Fig. 3 Mortality rates 1960–2000, England and Wales (10)

Source: Eurostat, general and regional statistics, data sets 2008

Apart from mortality in children under the age of one year, death rates among young people are highest during late adolescence (ages 15–19). For example, there were 430 deaths of young people aged 10–14 in the United Kingdom in 2006, but there were 1654 recorded deaths among the 15–19 age group (11), primarily due to preventable deaths caused by injury, self-poisoning and road traffic accidents. Just over 1000 young people aged 15–24 die each year in the United Kingdom as a result of accidents, and the majority are road-traffic related (11).

The majority of the United Kingdom school-aged population appear to enjoy good health and high life satisfaction. However, the health of young people is differentially structured by socioeconomic inequalities, age, ethnicity and gender. For example, girls have poorer self-rated health and boys are more likely to be injured or be a victim of violence. Although boys are more likely to engage in risk behaviours, girls have been closing this gap; they are more likely to smoke and be vulnerable to the serious effects of excessive alcohol consumption. Internationally, the United Kingdom compares well for the school experience and

supportive friendship networks but poorly for some health risk behaviours, such as alcohol misuse (12).

Health risk behaviours are not simply risky or “bad” choices made due to poor judgement and immaturity; the apparent “choices” made by children and young people are constructed through the lens of social determinants. To improve young people’s health and well-being, it is important to understand how young people are socially and economically positioned and, as a result, come to feel about their lives. Children and young people in the United Kingdom are increasingly living “accelerated lives” (13), reaching physical, emotional and social milestones at younger and younger ages, often without the necessary supports in place to protect the vulnerable or immature.

The major concerns for young people’s health in England are the following.

- **Violence, abuse, and injury** (either accidental or intentional) – from both peers and others. In 2007, nearly 28 000 children in the United Kingdom, over 16 000 of whom were of school age, were identified as being at risk of serious abuse from their parents or other carers and placed on child protection registers. Recent data from London indicate that one third of all victims of rape and sexual offences are children, predominantly girls aged under 17 years; over a quarter (27%) of young people aged 10–25 had been a victim of either personal theft or of assault in the last 12 months (males were significantly more likely than females to have been a victim of assault) (14).
- **Longstanding illness or disability** among the school-aged population (5–19 years), primarily asthma, epilepsy and diabetes followed by autism and behavioural disorders, which over the last 10 years among 2–15-year-olds has fluctuated between 20% and 29% for boys and 16% and 25% for girls (15).
- **Conduct disorders** among young children and **poor mental health** among some young people. Although the majority of children and young people report being happy and satisfied with their lives, this has been an issue of public and policy concern in recent years (4). The prevalence of all mental disorders in young people has remained relatively unchanged over the past five years at about 12–13% for boys and 9–10% for girls aged 11–15 years (16,17). The disparity between boys and girls in relation to emotional disorders increases with age: while 22% of boys and 27% of girls in England at age 11 report feeling low at least once every week, by age 15 the proportion reporting regularly feeling low has increased to 24% among boys and an alarming 46% among girls (12). Teenage girls are almost twice as likely to self-harm as boys and it appears that girls in the United Kingdom may be at higher risk of translating self-harming thoughts into behaviour than young people from other countries such as Australia and the Netherlands (18). In contrast, it is young men who are at greatest risk from extreme feelings of hopelessness and suicide, with older male adolescents most at risk (19). Suicide among the younger school-aged population is rare (22 deaths in 2006 for under 14-year-olds), but among the 15–24 age group this figure for 2006 jumped to 543, the overwhelming majority of whom (431) were male (20).
- **Sexual health:** early sexual intercourse is one element of a set of health risk behaviours, each of which reinforces other risk-taking behaviour and puts the individual at increased risk of negative outcomes, including pregnancy, sexually transmitted infections (STIs) and low educational attainment (21). Sexual initiation in early adolescence is associated with other risk behaviours such as substance misuse, most notably alcohol consumption (22). Moreover, sexual initiation earlier than age 14 is linked with lower self-rated quality of life in girls and higher levels of psychosomatic health complaints such as regular headaches, stomach aches and feeling low (23). The incidence of STIs, including Chlamydia and gonorrhoea, have also risen substantially over the last decade, with consequent impacts on health and fertility if left untreated.
- **Teenage pregnancy:** over the last decade, considerable policy attention has been given in England to a reduction in teenage pregnancy rates. Since 1998, data suggest a general downward trend in the teenage conception rate (see Fig. 2), but conception rates remain high among the most vulnerable teenagers. For example, young people in and leaving care are at high risk of pregnancy; looked-after children are likely to become sexually active earlier than other groups of children. Twenty-five per cent of care leavers have had a child by the age of 16 and almost half are mothers within 18 to 24

months of leaving care. Higher levels of sexual risk-taking among more disadvantaged young people, coupled with only a small decline in the under-16 conception rate, indicates that the challenges for improving the sexual health of adolescents are considerable. We have much to learn from our European partners in this respect.

- **Alcohol:** the United Kingdom has higher numbers of young people drinking alcohol regularly and to the point of drunkenness than many other countries in Europe and North America (23,24). Recent findings indicate that in the United Kingdom, over 88% of 16-year-olds surveyed have consumed alcohol in the last 12 months and 57% have been drunk at least once over the past year (24), with between 12% to 14% of young people aged between 15 and 11 years in England, Wales and Scotland reporting more than four episodes of lifetime drunkenness (12). Children and adolescents are especially vulnerable to alcohol poisoning due to a lower body mass and metabolic processing of alcohol. Over the last decade, excessive alcohol consumption has also resulted in an increasing number of under-18s being admitted to hospital for an alcohol-related condition, particularly alcohol poisoning (25). During 2005/2006, nearly 9000 young people under 18 years were admitted to hospital in England as a result of alcohol consumption.
- **Substance misuse and smoking:** alcohol apart, levels of substance misuse and levels of smoking among United Kingdom teenagers appear to be in a downward trend (24). Smoking in particular is less prevalent among children and young people in the United Kingdom than in other European countries, with 22% reporting having smoked a cigarette in the last 30 days compared to a European average of 29% (24). In 2007, 19% of girls and 12% of boys in the United Kingdom were regular smokers; this represents a significant reduction from the rates two years previously of 25% for 15-year-old girls and 16% for boys (24). Use of cannabis is relatively common among the school-aged population in the United Kingdom, with about one third of young people reporting ever having tried the drug (23,24). However, the proportions using cannabis appear to be in decline since 2002 in England (26). The proportion of school-aged pupils who use any form of drug, including class A drugs and other drugs such as solvents, is relatively low in the United Kingdom at around 6.5% of 11–15-year-olds.
- **Physical activity, obesity and overweight:** active lifestyles have been demonstrated to have an array of positive impacts on health and emotional well-being (27), but worldwide many children's and young people's lives are becoming increasingly sedentary (23). Identifying and promoting ways to sustain an active lifestyle among children and young people in the United Kingdom has become a policy priority; we are introducing innovative approaches to obesity and overweight, notably through the Change4Life programme (a society-wide movement that aims to prevent people from becoming overweight by encouraging them to eat better and take more exercise). The underlying strategy, *Healthy weight, healthy lives* (28), was lauded as an excellent model to tackle obesity by many prestigious health organizations in the United States in a letter to President Obama in June 2009. Gender and socioeconomic differences are nevertheless a particular concern. In 1995, 11% of children aged 2–15 years were classified as clinically obese; a decade later, this had risen to 16%. More boys (17%) than girls (15%) are likely to be obese. Overall levels have fallen slightly from a high in 2005 of 18%, indicating a possible future downward trend (27). Social determinants appear to play a significant role in the construction of childhood obesity; in 2006, 20% of both genders among the lowest income group were obese, while among the highest income group, 15% of boys and 9% of girls could be classified as obese.
- **Young people with particular vulnerabilities:** certain groups of young people are particularly susceptible to poor health outcomes. These include young people who have been in trouble with the law (particularly those in secure units and detention centres), young carers, asylum seekers and refugees.

Health system context and health services available for young people

Services and care from the National Health Service (NHS) are funded centrally from taxation⁹ and are free at the point of use for anyone who is resident in the United Kingdom – more than 60 million people.

⁹In 2007/2008, the NHS received more than £90 billion in funding. The 2007/2008 budget roughly equates to a contribution of £1500 for every man, woman and child in the United Kingdom.

The NHS in England is divided into two sections: primary and secondary care (Fig. 4).

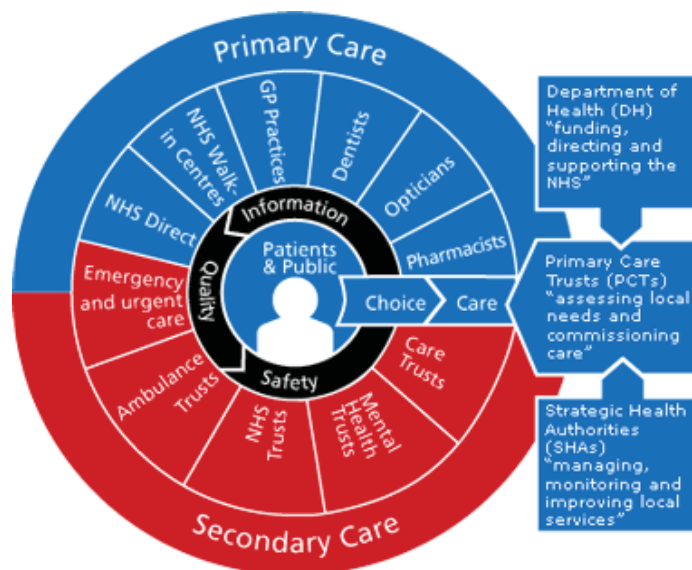


Fig. 4 Structure of NHS in England

Primary care is generally regarded as a “front-line” service. It is the first point of contact for most people and is delivered by a wide range of independent contractors such as general practitioners (GPs), dentists, pharmacists and optometrists. Secondary care (acute health care) can be either elective care or emergency care. Elective care means planned specialist medical care or surgery, usually following referral from a primary or community health professional such as a GP. Primary care trusts (PCTs) are in charge of primary care and have a major role in commissioning secondary care and providing community care services. They are now at the centre of the NHS, controlling 80% of the NHS budget and overseeing 29 000 GPs and 18 000 NHS dentists.

Public health interventions begin before birth, with parental support and advice about diet, physical activity, immunizations, smoking and alcohol, and continue after birth with breastfeeding support, regular examinations, advice on infant feeding, oral health, accident and injury prevention and the emotional health of parents and child. There is intensive support for parents and child in the first five years of life (under the 0–5 Healthy Child programme) through health visitors and general practice, and then, as the child enters formal schooling, through the National Healthy Schools programme, the school nursing service and mainstream NHS and other support services. The thrust of recent adolescent health policy and service development is to ensure that this support continues throughout and meets the specific needs of later childhood and adolescence.

Health care services for young people in England are provided in a range of settings from:

- GP surgeries, which, after the individual registers with the practice, provide general medical advice and treatment, prescriptions (free to under 16s, those under 18 in full-time education or on low income), referral to a specialist or hospital, immunizations and tests;
- NHS dentists (free six-monthly check-ups are recommended) and ophthalmologists;
- pharmacists, who dispense prescriptions and can offer health advice;
- NHS walk-in centres, which offer confidential advice and treatment for minor injuries and illnesses (they are open seven days a week, from early until late, and an appointment is not necessary);
- the accident and emergency (A&E) department at a hospital (when seriously ill and in need of emergency care) or by calling “999” for an emergency ambulance; and
- a range of community-based health care facilities, including drop-in centres specifically targeted at young people, services provided in schools and further or higher education institutions, mobile

clinics, services provided in youth facilities such as youth centres and sexual health and reproductive services in the community, often provided by third sector organizations and charities; these sorts of services are often particularly effective at reaching especially vulnerable or “hard-to-reach” young people, such as travellers or asylum seekers.

Only 20% of all disease and illness among young people results in a consultation with a GP (29), the vast majority of health problems being managed at home under the care of parents or guardians. Consultation rates with a GP in childhood appear to have remained relatively stable over the last decade at about two consultations per young person per year, but young people’s average consultation times are shorter than for children or adults (30). Among young men the consultation rate remains constant through to early adulthood, but for young women, late adolescence (15–19 years) marks a doubling of GP consultations to four per year (31).

In relation to young people’s experience of general practice, a recent questionnaire study (32) reported that 23% of 12–15-year-old girls surveyed felt either “quite uneasy” or “very uneasy” with their doctor during their most recent consultation, with highest rates of unease being found among younger girls. The most common reasons for young people to consult a GP have been identified as respiratory conditions (35%) and dermatological problems (29%) (33). There is evidence that relatively few young people look to general practice as a means of support for emotional well-being, with young people more likely to turn to family and friends as a means of addressing negative and distressing feelings. This illustrates how important it is for vulnerable young people, such as those in public care, to be able to access a supportive adult who will respond to their worries and concerns.

As regards young people’s use of hospital services, inpatient bed use increases in adolescence and is especially marked in mental health admissions, where inpatient admissions increase 14-fold between ages 11 and 15 (34). Inpatient and outpatient hospital attendances for 10–19-year-olds have increased more than 10% in recent years (notably for asthma, epilepsy and diabetes) (1).

Consultations with young people over a number of years reveal that there is considerable mistrust of health and allied services, with widespread fears about confidentiality. The Royal College of Paediatrics and Child Health has acknowledged the shortcomings within the health system: lack of access to primary health care; concerns about confidentiality, consent and privacy; insufficient education of health professionals; and absence of dedicated hospital wards (35). Young people are often not aware of health and support services available to them and how they can access them. Many services are not very youth friendly, or are inaccessible at times when young people need them. Changes to working practices and workforce development are in place, and although there is still room for improvement, considerable progress is being made to make services more young-person friendly and accessible.

Over the past decade or so, it has increasingly been recognized that the needs of young people as regards their access to, and use of, health services are quite distinct from those of children or adults, and that different skills and approaches are required of those who work with and treat them. Accordingly, a range of initiatives has been introduced in that time to improve the skills and knowledge of medical staff working with young people (see below).

Confidentiality is an issue that concerns both young people (who are anxious that the content of consultations remains confidential) and professionals, who are not always confident about the rules governing consent and confidentiality. While many GP practices take great pains to explain their policies on confidentiality to their young patients, some young people will prefer to access care and advice elsewhere: confidential drop-in centres, located at school or in the community, offering information and advice on sexual and other matters, are popular, as are the increasing numbers of pharmacists offering advice, as well as online sources of support.

Whether or not a child or young person under 16 is able to receive health care treatment without needing consent from a parent or carer will depend on whether they are judged “Gillick competent” or able to meet the “Fraser guidelines”. These terms refer to a 1982 legal case that looked specifically at whether doctors should be able to give contraceptive advice or treatment to young people under 16 years without parental consent. Since then, they have been more widely used to help assess whether a child has the maturity to make his or her own decisions and to understand the implications of those decisions.

Support and advice is available for young people in England online and through dedicated phone lines. Such advice can be particularly powerful in that it is accessed by young people on their own terms, and can carry guarantees of anonymity should young people want it. A wide range of support services are available. The “FRANK” campaign, for instance, launched in 2003, provides online and over-the-phone information and support for young people about the risks and dangers of drugs and their use. The “FRANK” helpline, which operates 24 hours a day, 7 days a week, handles over 1000 calls a day and the web site receives over 2 million visitors a year (36). “RU thinking” is a web site promoting safe sex, sexual awareness and sex education in teenagers. “Teenage health freak”, run by two GPs, provides web-based, accurate and reliable health information to teenagers in a contemporary, entertaining and informative way. The NHS “Teen life check” is a quick quiz-style online questionnaire for young people between 11 and 14 designed to empower young people to take responsibility for their life choices; it has involved young people in its development and design from the outset.

Recent initiatives

In 2003, in the wake of Lord Laming’s inquiry into the murder of the child Victoria Climbié in 2000, the government published the Green Paper *Every child matters* (37). In the preceding consultation, children and young people had identified five outcomes that mattered most to them. These were:

- being healthy: enjoying good physical and mental health and living a healthy lifestyle;
- staying safe: being protected from harm and neglect;
- enjoying and achieving: getting the most out of life and developing the skills for adulthood;
- making a positive contribution: being involved with the community and society and not engaging in antisocial or offending behaviour; and
- economic well-being: not being prevented by economic disadvantage from achieving their full potential in life.

These five outcomes were given legal force in the Children Act 2004 and the five *Every child matters* outcomes have become the foundation for much policy since, including *The children’s plan* (38), *Choosing health* (39), the *National service framework for children, young people and maternity services* (40), and the children and young people’s health strategy, *Healthy lives, brighter futures* (2).

Working with and supporting children, young people and their families to achieve the outcomes set out in *Every child matters* is a multidimensional challenge that requires a wide range of interdependent policy responses, recognizing the mutual dependency of all five outcomes, notably the inextricable link between good physical and mental health and the ability to learn and achieve (*Choosing health* (39) reiterated that: “people’s patterns of behaviour are often set early in life and influence their health throughout their lives. Infancy, childhood and young adulthood are critical stages in the development of habits that will affect people’s health in later years.”). It set out the principles for supporting the public to make healthier and more informed choices with regards to their health, promising:

- new sources of information, guidance and practical support for parents, carers, children and young people;
- services coordinated to meet the needs of children, young people and their parents; and
- services being brought together in one location as part of integrated service delivery through children’s trust arrangements.

In June 2009, the President of the Royal College of General Practitioners highlighted the importance of improving the appropriateness of health services for young people, with:

- more responsive services that recognize the physical, mental and psychological needs of young people during adolescence;
- improved communication skills so that health teams facilitate better support and shared decision-making about treatment and care plans and to create opportunities for health promotion;
- greater partnership working to enable implementation of smoother transitions between child and adult services so that young people do not get lost in the system; and
- encouraging the views of young people to be included during the commissioning cycle so that local arrangements are reflective of needs.

The national service framework for children, young people and maternity services

National service framework for children, young people and maternity services (NSF) (40) proposed a fundamental change in the way we think about children's and young people's health, with child-centred services that look at needs in terms of the whole child, identifying problems early, taking preventative action to ensure children and young people have the best possible chance to fulfil their potential. The 10-year programme set 11 standards for all organizations providing services to children and their delivery partners and included the requirement to introduce a child health promotion programme.

The NSF is designed to:

- give children, young people and their parents increased information, power and choice over the support and treatment they receive, and involve them in planning their care and services;
- introduce a new child health promotion programme designed to promote the health and well-being of children from pre-birth to adulthood;
- promote physical health, mental health and emotional well-being by encouraging children, young people and their families to develop healthy lifestyles;
- focus on early intervention based on timely and comprehensive assessment of a child or young person and their family's needs;
- improve access to services for all children and young people according to their needs, particularly by co-locating services and developing managed local clinical networks for children who are ill or injured;
- tackle health inequalities, addressing the particular needs of communities, children and their families who are likely to achieve poor outcomes; and
- promote and safeguard the welfare of children and young people and ensure all staff are suitably trained and aware of action to take if they have concerns about a child or young person's welfare.

The NSF included among its standards one specifically related to listening and responding to children and young people and parents. It endorsed the increasing number of "healthy schools" operating under the National Healthy Schools programme, leading the way to improving children and young people's health. In addition, it encouraged schools to develop into "extended schools", providing health, social care and other services for children and young people, their families and the wider community. Children's centres, offering integrated early-years education, family and parenting support and health support, were started in the most disadvantaged areas.

A review of progress in late 2007 (41) demonstrated that the advent of strategic health authorities and children's trust arrangements, together with the appointment of directors of children's services in local authorities, was helping to change the way services were jointly commissioned with primary care trusts. It applauded the changes and improvements to child and adolescent mental health services (CAMHS) and the emphasis on early intervention and prevention which helps children develop emotional resilience so that they can cope better with episodes of bullying and violence. But the overarching message was unequivocal: "Turning the vision set out in the national service framework into reality for children, young people and their families calls for nothing less than the transformation of the NHS" (41). It called for stronger partnership

working and collaboration, for the greater engagement of mothers and fathers, children and young people who use the services, for early intervention and preventative care, appropriate workforce development and responsibility for delivery to be further devolved to local level.

Since the publication of the NSF, the national Healthy Schools programme has gone from strength to strength, with more than 99% of schools nationally now involved in the programme and over 76% of schools having achieved “national healthy school” status. More than 4 million children and young people are currently enjoying the benefits of attending a “healthy school”, where they say they feel healthier, happier and safer, while parents say they feel more involved in their children’s health and learning. Schools report that the programme has delivered sustained improvements in behaviour, standards of work and school management.

The White Paper *Your child, your school, our future: building a 21st century school system* (42), published in July 2009, puts a strong focus on child health as one of the key outcomes of the school system, as well as child attainment. It includes new duties on school governing bodies to promote health and complements plans to enhance the Healthy Schools programme. A Healthy Further Education programme is now under way to extend the principles of the national Healthy Schools programme to further education colleges and institutions.

School nursing services have a key role to play in delivering healthy schools and extended schools services as well as the personal, health and social education and sex and relationship education strands of the curriculum. They can also help to tackle obesity, encourage children to stop smoking, reduce teenage conceptions and STIs and support teenage parents, and coordinate packages of care for vulnerable children and their families. Their role in supporting young people both within and outside the school environment is clarified in the 5–19 Healthy Child programme.

The children and young people’s health strategy

In December 2007, the Government made a commitment in *The children’s plan* (28) to publish a child health strategy jointly between the Department of Health and the Department for Children, Schools and Families. *Healthy lives, brighter futures: a strategy for children and young people’s health* (2) was published in early 2009.

The strategy recognizes that adolescence is not only a key transition point between childhood and adulthood, but is also a distinct developmental stage in its own right, characterized by dramatic physical and neurological changes and emotional development. It also recognizes the importance of young people’s mental health and psychological well-being to their personal and social development, as the foundation upon which so many other choices – about sex and relationships, alcohol, smoking and drugs, physical activity, eating habits etc. – depend. Early intervention when young people first experience mental distress, building young people’s resilience and providing them and their families with appropriate support, is therefore seen as crucial.

The strategy includes a commitment that as well as services being available in a school or other education setting, young people should find that services are offered in a way and with a focus that speaks to their particular needs as they grow older. This includes, for example, accessible sexual health advice and integrated youth support services providing information, advice, healthy opportunities and support. They should also expect a range of positive activities such as sports, leadership and volunteering, drama and music. It is crucial that those young people who need ongoing contact with health services or support benefit from early planning for transition to adult physical or mental health services.

The strategy showcased examples of services applying the principles originally espoused in the NSF, such as the provision of dedicated adolescent units in hospitals (see Box 1).

Box 1

The Melanie Richardson Adolescent Unit is a 12-bedded unit within the Oxford Children's Hospital, comprising two four-bed wards and four single rooms, complete with dayroom, school room and high-tech equipment and facilities such as broadband access which helps the young people maintain links to their schools. It mainly treats 13–16-year-olds (excluding those who require obstetric and significant mental health services) plus some older young people with long-term conditions. There is a strong focus on outpatient and day-care facilities, allowing young patients wherever possible to return home at night, as they prefer. The hospital's young people executive (YiPPEE), consisting of over a dozen 8–15-year-olds, advises on design and approach. Nurses on the unit liaise with up to 30 different consultants who provide care for the young patients.

Healthy lives, brighter futures contains a specific section on “making health services young-people friendly”, with the following expectations.

- Local areas, through the children's trust, will set out what children, young people and families can expect from their health services locally. This will help make services more visible to young people in their areas.
- There will be promotion of services that provide the full range of advice, support and care that young people need, services that help them make healthy choices and give them access to healthy opportunities. Exploration of different types of adolescent health provision will continue. Confidential drop-in centres, located at school, college or in the community, offering information and advice on a wide range of health and well-being topics, are popular with young people and are increasingly being developed.
- Learning from the four teenage health demonstration sites will be disseminated widely to help others plan their services for young people. This initiative has been exploring the essential elements for successful adolescent health services. Key factors for consideration when planning services include the type and location of settings, the mix of drop-in and by-appointment services, and the balance of types of staff who are experienced and skilled at working with young people.
- That the *You're welcome* (43) quality criteria will be rolled out across England so that all young people, wherever they live, will be able to access youth-friendly health services.

The strategy also highlights the need to enhance the evidence and skills to inform policy and practice for young people's health services in a number of ways, including:

- promoting workforce skills and training and the potential for academic chairs in adolescent health (see below);
- exploring the potential for a flexible, skilled specialist adolescent health and well-being workforce offering a range of health and social care in a variety of settings, as determined by local needs
- assessment, focused on early intervention and health promotion, with a strong emphasis on mental health and psychological well-being;
- endorsing the systematic involvement of young people and their parents in service development, supported by accredited frameworks for young people's involvement such as “Hear by right” (44); and
- strengthening the evidence base on young people's health and well-being, and in particular on interventions to support young people in adopting more healthy behaviours.

***You're welcome* quality criteria**

The Department of Health *You're welcome* (43) quality criteria are designed to improve the quality of adolescent health care, recognizing that the needs of young people are distinct and different from those of children and adults. *You're welcome* addresses the need for services to be friendly to young people under the age of 20, providing holistic care and “joined-up working” at local service level. Improved health services should encourage take-up by young people and so contribute to better health outcomes.

The quality criteria are intended to underpin all development of health services aimed at adolescents, strengthening the increased focus on their needs and on training the workforce to respond better to those needs. They are endorsed and supported by a number of key professional bodies, including the Royal College of Paediatrics and Child Health, the Royal College of Nursing and the National Youth Agency. Young people have been involved in their development from the outset and are being encouraged to become *You're welcome* champions and participate as assessors in awarding *You're welcome* status.

The first version was produced in 2005, extended and piloted in 2007; a national support programme began in September 2008 and the national roll-out was announced in *Healthy lives, brighter futures (2)*.

The criteria support the implementation of standards 4 and 9 of the NSF (40). The expectation that by 2020 all services for young people will be *You're welcome* accredited underpins the 5–19 Healthy Child programme.

The *You're welcome* quality criteria are based on examples of effective practice working with young people aged under 20 and are designed to be applied to all health services – both young people-specific and generic – covering general and acute health problems, chronic and long-term disease management (such as specialist care for asthma and diabetes) and health promotion.

The criteria cover ten topic areas:

1. accessibility
2. publicity
3. confidentiality and consent
4. the environment
5. staff training, skills, attitudes and values
6. monitoring and evaluation, and involving young people
7. joined-up working
8. health issues for adolescents
9. sexual health and reproductive health services
10. CAMHS.

The *You're welcome* quality criteria have been included in the NHS operating framework for 2009/2010. To complement this, all nine government offices have now been supported to put into place a regionally based support programme for *You're welcome*, which has been included in the Department for Children, Schools and Families' children's services improvement support for local authorities and children's trusts.

The *You're welcome* quality criteria will help primary care trusts and children's trusts to do the following.

- **Commission high-quality health services that make young people, and other service users, feel comfortable.** This will generate direct and indirect benefits for all age groups through, for instance, improvements in accessibility, publicity, confidentiality and consent, the environment, staff attitudes and values, and joined-up working. By 2020, the Department of Health hopes all health services regularly used by young people – including all school and further education-based services – will carry the *You're welcome* quality mark, a sign that they are young-people friendly.
- **Strengthen teenage pregnancy strategies to reach vulnerable groups and young people living in high-deprivation rate wards,** by offering an opportunity to develop trusted services for young people most at risk by, for example, general practices serving “hotspot” wards, school and further education-based services and “one-stop shops”.
- **Improve provision around children's and young people's psychological health and well-being.** CAMHS components are included in the main body of *You're welcome* to ensure all health services

consider these issues as part of their “core offer”. An additional section for targeted and specialist CAMHS services (section 10) has been produced with support from Care Services Improvement Partnership and the Mental Health Act implementation team.

A copy of the *You're welcome* quality criteria can be found at: www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_073586

Human resources for young people's health

E-learning

The Royal College of Paediatrics and Child Health, with funding from the Department of Health, has led the development of an interdisciplinary e-learning resource for adolescent health. The materials produced as part of the “Adolescent health project” (AHP) (45) aim to ensure that all doctors and nurses have the necessary skills to help their young patients lead healthier and more active lives.

The AHP includes face-to-face learning as well as a set of detailed e-learning modules covering all aspects of adolescent health, including development, communication skills, consent and confidentiality issues, sexual health, substance misuse, obesity and eating disorders, mental health and making health services young-person friendly. They are designed to help doctors, nurses and other health professionals communicate with and work with young people more effectively and help prevent problems developing. The materials are provided free to all professionals working in the NHS and other health care professionals.

A range of modules has been divided into topics and sessions, pitched at differing levels to suit the educational needs of a variety of health care professionals working with adolescents. The materials have been written by subject specialists and experts in their particular field and have been subjected to extensive peer review. Many sessions incorporate video clips and case studies to help trainees understand the views of young people and professionals on a host of subjects, from confidentiality and self-harm to puberty and acne. The sessions vary in length, with many around 20 minutes, to fit in with busy work/study lives.

These resources have been produced in collaboration with the Royal College of General Practitioners, the Royal College of Nursing, the Royal College of Paediatrics and Child Health, e-Learning for Healthcare and other royal colleges. The e-learning package is now under development for a range of other professionals working with young people, such as youth workers.

Academic chairs in adolescent health

Healthy lives, brighter futures (2) announced the intention to explore the potential for establishing a number of academic chairs in adolescent health to advance understanding of adolescence and how best to meet young people's health needs through appropriate education and service provision. The creation of such chairs would significantly raise the profile of adolescent health, complementing its current heightened focus in line with initiatives such as the Royal College of Paediatrics and Child Health's AHP e-learning venture (see above) and the recent foundation of the Association for Young People's Health (the national body promoting and raising awareness of adolescent health and well-being issues, relevant training, standards and professional development).

Healthy youth work

Non-health professionals working with young people also need a basic understanding of healthy development to support them in their roles. The National Youth Agency has recently developed healthy youth work guidelines (46) to ensure that youth workers have the skills to support young people's health and well-being. Young people have 1 million contacts with youth workers each month, providing a valuable opportunity to offer well-informed health information, advice and guidance.

The guidelines split the key areas of health that affect young people into four strands:

- **healthy lifestyle** (issues that underpin a healthy life such as a balanced and healthy diet);
- **mental and emotional well-being** (such as all aspects of emotional literacy, bullying, self-harm etc.);
- **healthy relationships and sex** (including sexual development, handling early relationships and delaying early sexual activity, contraception and access to advice and services); and
- **substance use** (the use of prescribed drugs, tobacco and alcohol as well as illegal drugs).

There are three levels of delivery within each area – core, regular and advanced – so that practitioners can increase their skills and input incrementally.

Conclusions

Young people's health in England is now firmly established as a priority for policy-makers, educationalists and commissioners. We have already made groundbreaking strides in workforce development and training, in developing youth-friendly services and in involving young people in service improvement, and the current policy and societal environments are extremely favourable for further advances. The necessary strategies (such as the children and young people's health strategy) are in place and the Healthy Child programme will provide the framework within which good physical and mental health services can be further developed.

The challenge now is to maintain the momentum that has built up over the past years and ensure that the spotlight remains on the health of young people and the services needed to promote and protect their health.

The following factors are crucial.

- The role of parents/carers and the wider family in healthy adolescence. Increasing knowledge about the distinct developmental stages of adolescence, as well as the support and advice available, needs to be shared not only with professionals, but also with parents/carers and young people themselves.
- Sustainability: funding for public health interventions is frequently susceptible to budget cuts in times of recession. The fact that, as the chief medical officer has pointed out, the effects of poor health during adolescence can last a lifetime, and that keeping adolescents healthy is a valuable investment in the nation's future, needs to be reiterated and emphasized continuously. Those who work in this area need to press their case repeatedly and consistently, and young people can be among our most powerful allies here.
- The building of partnerships between the wide range of stakeholders involved: health and education, local government and the NHS, other service providers such as youth workers and the third sector and, importantly, partnerships between service providers and users – young people, their parents and communities. These partnerships should help to break down some of the traditional barriers that have for too long undermined the development of holistic services designed around the person, not the system.
- The involvement of young people and their parents/carers and wider families and communities in the development and monitoring of services.
- The need to ensure that we build-in and maintain effective evaluation (as has been the case, for example, with the evaluation of the national Healthy Schools programme) to ensure that all interventions are evidence based and offer value for money.
- The continuous professional development of all those who work with young people and their parents and carers to ensure they have the appropriate skills and keep abreast with the latest approaches and research.
- The development of a robust evidence base and supporting data to underpin the development of services for young people.
- Children's trusts: these organizations are shortly to be placed on a statutory basis and the requirement for GPs, schools and the further education sector to sit around the table will further strengthen their impact and influence.
- The roll-out of the *You're welcome* quality criteria across primary care and in time to all settings offering health services to young people will embed these principles in everyday practice.
- The statutory status of personal, social and health education (PSHE) in schools will help young

people better understand both the risks and benefits of certain life choices, but also empower them to make best use of health and related services.

- The proposed establishment of academic chairs in adolescent health and the growth of the membership of the Association for Young People's Health will help to raise the profile of adolescent health as a specialized area of practice.

Adolescence is not just a staging post between childhood and adulthood. It is an exciting, sometimes bewildering time (both for young people and their parents/carers) in which enormous physical and psychosocial changes take place, alongside growing autonomy and responsibility for decision-making. We fail our young people if we do not ensure that everything possible is done to help them travel the sometimes rocky road to adulthood safely.

References

1. Donaldson L. Under their skins: tackling the health of the teenage nation. In: *Annual report of the chief medical officer on the state of public health 2007*. London, Department of Health, 2008.
2. *Healthy lives, brighter futures: the strategy for children and young people's health*. London, Department for Children, Schools and Families/Department of Health, 2009.
3. Kitchen S et al. *2005 DCLG citizenship survey*. London, DCLG, 2005 (<http://www.communities.gov.uk/documents/communities/pdf/452564.pdf>, accessed 10 July 2009).
4. Coleman J, Brooks F. *Key data on adolescence 2009*. Brighton, AYPH and TSA, 2009.
5. *Child poverty in UK. Second report of session 2003–04. House of Commons W.a.P. Committee*. London, The Stationery Office, 2004.
6. Brooks F. The health status of children and young people. In: Aggleton P, Dennison C, Warwick I, eds. *Promoting health and wellbeing through schools*. London, Routledge, 2010.
7. *Freedom's orphans*. London, Institute for Public Policy Research, 2006.
8. *Time trends in parenting and outcomes for young people*. London, Nuffield Foundation, 2009.
9. *Policy review of children and young people*. London, HMT/DfES, 2007.
10. *Deaths by age, sex and underlying cause in England and Wales, 2003*. London, Office for National Statistics, 2004.
11. Donaldson L. *On the state of public health: annual report of the chief medical officer 2007*. London, Office for National Statistics, 2008.
12. Brooks F et al. *Young people's health in Great Britain and Ireland: findings from the Health Behaviour in School-aged Children study*. Hatfield, University of Hertfordshire, in press.
13. Currie C et al., eds. *Young people's health in context. Health Behaviour in School-aged Children (HBSC) study: international report from the 2001/2002 survey*. Copenhagen, WHO Regional Office for Europe, 2004 (Health policy for children and adolescents No. 4; http://www.euro.who.int/document/e82923_part_1.pdf, accessed 2 September 2009).
14. *The state of London's children report*. London, Greater London Authority, 2007.
15. Nessa N. *Disability. The health of children and young people*. London, The Stationery Office, 2004.
16. Meltzer H et al. *Mental health of children and adolescents in Great Britain*. London, The Stationery Office, 2000.
17. Green H et al. *The mental health of children and young people in Great Britain*. London, Palgrave Macmillan, 2005.
18. Madge N et al. Deliberate self-harm within an international community sample of young people. *Journal of Child Psychology and Psychiatry*, 2008, 49:6:667–677.
19. Bradford S, Urguhart C. The making and breaking of young men: suicide and the adolescent male. *Youth and Policy*, 1998, 61:28–41.
20. *Samaritans' information resource pack*. London, The Samaritans, 2008.
21. Godeau E et al. Factors associated with early sexual initiation in girls: French data from the international survey Health Behaviour in School-aged Children (HBSC)/WHO. *Gynécologie, obstétrique & fertilité*, 2008, 36:2:176–182.
22. Robertson J, Plant M. Alcohol, sex and risks of HIV infection. *Drug and Alcohol Dependence*, 1988, 22:1:75–78.
23. Currie C et al., eds. *Inequalities in young people's health. Health behaviour in school-aged children: international report from the 2005/2006 survey*. Copenhagen, WHO Regional Office for Europe, 2008 (Health policy for children and adolescents No. 5; http://www.euro.who.int/datapublications/Publications/Catalogue/20080616_1, accessed 16 June 2009).
24. Hibell B, Guttormsson U. *The European School Survey Project on Alcohol and Other Drugs. The 2007 ESPAD report*. Stockholm, The Swedish Council for Information on Alcohol and Other Drugs (CAN), 2009.
25. Miller E et al. Alcohol skills training for college students. In Monti P et al., eds. *Adolescents, alcohol and substance abuse*. New York, NY, Guilford Press, 2001:183–215.
26. Fuller E, ed. *Drug use, smoking and drinking among young people in England 2007*. London, The Information Centre, 2008.
27. Brooks F, Magnusson J. Taking part counts: adolescents' experiences of the transition from inactivity to active participation in school-based physical education. *Health Education Research*, 2006, 21:6:872–883.
28. *Healthy weight, healthy lives: a cross-government strategy for England*. London, Department of Health, 2008.
29. Bruijnzeels M et al. Everyday symptoms in childhood: occurrence and general practitioner consultation rates. *British Journal of General Practice*, 1998, 48:426:880–884.
30. Jacobson LD, Wilkinson C, Owen P. Is the potential of teenage consultations being missed? A study of consultation times in primary care. *Family Pract*, 1994, 11:296–299.

31. Hippisley-Cox J et al. *Trends in consultation rates in general practice 1995 to 2006: analysis of the QRESEARCH database. QRESEARCH research highlights*. Leeds, The Information Centre, 2007 (<http://www.ic.nhs.uk/statistics-and-data-collections/primary-care/general-practice/trends-in-consultation-rates-in-general-practice-1995--2006>, accessed 10 July 2009).
32. Balding J. *Young people into 2007*. Exeter, Schools Health Education Unit, 2007.
33. Churchill R et al. Do the attitudes and beliefs of young teenagers towards general practice influence actual consultation behaviour? *British Journal of General Practice*, 2000, 50:461:953–957.
34. *National In-patient Child and Adolescent Psychiatry Study (NICAPS)*. London, College Research Unit, Royal College of Psychiatrists, 2001.
35. *Bridging the gaps: health care for adolescents*. London, Royal College of Paediatrics and Child Health, 2003.
36. *FRANK review 04/06*. London, Department of Health/Home Office/Department for Children, Schools and Families, 2006.
37. *Every child matters*. London, The Stationery Office, 2003.
38. *The children's plan: building brighter futures*. London, Department for Children, Schools and Families, 2007.
39. *Choosing health*. London, Department of Health, 2004.
40. *National service framework for children, young people and maternity services*. London, Department of Health, 2004.
41. *Children's health, our future: a review of progress against the national service framework for children, young people and maternity services 2004*. London, Department of Health, 2007.
42. *Your child, your schools, our future*. London, Department for Children, Schools and Families, 2009. (<http://www.dcsf.gov.uk/21stcenturyschoolssystem/>, accessed 10 July 2009).
43. *You're welcome. Quality criteria for making health services young people friendly*. London, Department of Health, 2007 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_073829.pdf, accessed 25 November 2009).
44. Hear by right [web site]. Leicester, National Youth Agency, 2009 (<http://hbr.nya.org.uk/>, accessed 10 July 2009).
45. Adolescent health project [web site]. London, Royal College of Paediatrics and Child Health, 2009 (<http://www.rcpch.ac.uk/Education/Adolescent-Health-Project>, accessed 10 July 2009).
46. *Good practice guidelines for healthy youth work*. Leicester, National Youth Agency, 2008.

United Kingdom (Scotland): successful interprofessional practice in Dundee

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Executive summary

Dundee is Scotland's fourth largest city. Out of the 976 most-deprived of Scotland's 6505 data zones, 53 are in the Dundee City Council area. Over a quarter (28.4%) of Dundee's population lives in these data zones. There is a high rate of unemployment and a third of localities have more than twice the national average unemployment rate. Dundee City also shows higher than national average rates of drug misuse, smoking, teenage pregnancy and pregnancy termination.

"The Corner" young people's health and information service (<http://www.thecorner.co.uk>) is a working partnership involving Dundee City Council, the regional National Health Service (NHS) health board (NHS Tayside), the Scottish Government and young people. It provides a unique and integrated range of health and information services through its high-profile city centre drop-in facility and outreach work in local communities. "The Corner" has developed its practice based on the principles of the United Nations *Convention on the Rights of the Child*.

The multi-agency partnership at "The Corner" is committed to ensuring that services are relevant and youth friendly, and that they are continually reviewed and refined. Young people have played, and continue to play, a major role in shaping, designing and influencing services and direction. One in three young people from the main target group (11–18 years) in Dundee have used the drop-in facility. Services are all free, informal and confidential.

"The Corner" recognizes the challenge of balancing national priorities and targets with young people's health priorities. By firmly placing young people at the core of its work and seeing them as part of the solution rather than the problem, "The Corner" is well equipped to deal with dilemmas and sensitive issues in constructive ways.

Introduction

Dundee is Scotland's fourth largest city. It is situated to the north of the River Tay and has borders with Angus and Perth and Kinross councils. The local authority area covers 60 km². The area is compact and mainly urban.

Dundee City has a population of 142 150, of whom 16.6% are under the age of 16 years.

There is a high rate of unemployment and a third of localities have more than twice the national average unemployment rate. The number of people seeking help for drug misuse for the first time is significantly higher than in comparator authorities. There is a considerably higher percentage of families headed by a single parent in Dundee than for Scotland as a whole.

Scottish Index of Multiple Deprivation

The Scottish Index of Multiple Deprivation (SIMD) 2006 was released by the Scottish Executive in October 2006. It is a well-constructed deprivation index with a range of indicators in the following domains:

- current income
- employment
- health
- education, skills and training
- geographic access, telecommunication and housing
- crime.

Out of the 976 most-deprived of Scotland's 6505 data zones, 53 are in the Dundee City Council area. Over a quarter (28.4%) of Dundee's population lives in these data zones.

According to the Dundee joint health improvement plan 2005–2008, there are an estimated 44 646 smokers in Dundee City, representing 40.2% of the population aged 16–74 years. Dundee City also has one of the highest teenage pregnancy rates and highest pregnancy termination rates in Europe, and the infant mortality rate in Dundee is over a third higher than the rest of Scotland. Rates of unemployment in Dundee City are higher than elsewhere in Scotland, particularly among males.

The Scottish adolescent lifestyle and substance use survey (2002) found that among pupils in Dundee City:

- 5% of 13-year-olds and 23% of 15-year-olds were regular smokers; and
- 17% of 13-year-olds and 44% of 15-year-olds had drunk alcohol in the week prior to the survey.

Teenage pregnancy – national and local

The teenage pregnancy rate in Scotland is high compared to many other European countries and has been fairly steady for the past decade. In 2007, there were 8.1 pregnancies per 1000 in the under-16 age group; rates for those under 18 were 42.4 per 1000 and 58.6 per 1000 in the under 20s.

Dundee City Council had the highest teenage pregnancy rate within the region of Tayside at 18.6 per 1000 in the under-16 age group and 77.7 per 1000 in the under-18s. In 2006, 115 girls under 16 years became pregnant, giving the city a pregnancy rate of 15.3 per 1000 females. In Scotland as a whole, the rate for under-16s in 2006 was 7.6 per 1000. In total, 435 girls under 20 years became pregnant in Dundee in 2006, a rate of 83.9 per 1000 girls and the highest in the country.

The statistics reveal a key link with deprivation levels. According to data from the Scottish Government's Information and Statistics Division, the rate of teenage pregnancies for under-16s in the most-deprived areas in 2006 was more than four times higher than in the least-deprived areas.

"The Corner" young people's health and information service

"The Corner" young people's health and information service (<http://www.thecorner.co.uk>) is a working partnership involving Dundee City Council, the regional National Health Service (NHS) health board (NHS Tayside), the Scottish Government and young people. It provides a unique and integrated range of health and information services through its high-profile city centre drop-in facility and outreach work in local communities.

Following consultation with young people in Dundee in the early 1990s, the need was identified for health and information services that were exclusively designed for young people and which were informal and confidential. "The Corner" evolved from these consultations as a measured and considered response.

The interprofessional staff team combines the disciplines of nursing, health promotion, health sciences, community development and youth work. "The Corner" has developed its practice based on the principles of the United Nations *Convention on the Rights of the Child (1)*, with the best interests of young people at the core.

The multi-agency partnership at "The Corner" is committed to ensuring that services are relevant and youth friendly, and that they are continually reviewed and refined. Young people have played, and continue to play, a major role in shaping, designing and influencing services and direction. This is seen as vital if "The Corner" is to continue to be at the forefront of practice.

One in three young people from the main target group (11–18 years) in Dundee have used the drop-in facility.

Brief history

“The Corner” was created in response to concerns in both NHS Tayside and Tayside Regional Council about high levels of teenage pregnancy, the heterosexual spread of HIV, drug and alcohol use, attempted suicides by young people and the lack of appropriate services and information for young people.

“The Corner” set out to offer a *single-door*, or *one-stop-shop*, health and information service to young people from across the city. Its overall aim is to develop comprehensive, integrated and appropriate access to health and information services for young people in Dundee (11–25 years, with a specific focus on the 12–18 age group).

The long-term vision was that if young people were offered user-friendly, broad-based services, they would use and benefit from them and that this in turn would improve their health.

Although the original concerns of the health board and council focused on teenage pregnancy rates and the heterosexual spread of HIV, “The Corner” adopted a positive approach that would offer one-to-one advice and crisis intervention. This approach would also establish a culture that empowered young people to make positive choices for themselves in sexual health and issues which impacted on their own emotional and mental well-being.

Planning and implementation

Tayside Regional Council and NHS Tayside led a multidisciplinary working group to establish the principles of the service.

In addition to the appropriate location of the project, young people confirmed the types of services and approaches that would be required in an integrated health service. It needed to be a place:

- specifically for young people
- that was safe and welcoming
- where they could talk to someone of the same age
- that provided confidential services
- that provided family planning services specifically for young people
- that provided information to make choices.

“The Corner” is now jointly funded by NHS Tayside, Dundee City Council and the Scottish Government, employs 13 full-time and two part-time staff and is a registered charity.

Services

Services are all free, informal and confidential and include:

- a range of contraception and pregnancy testing services;
- information on a wide range of topics, including drugs, housing and training;
- one-to-one support, legal advice and employment services;
- access to computers and the Internet;
- events and interest-based opportunities focusing on a wide range of issues and needs, such as drama, multicultural and single-sex activities and mental health; and
- outreach with young people (“Corner carry-out”) in schools, colleges and community bases as well as detached work.

“The Corner” recognizes the challenge of balancing national priorities and targets with young people’s health priorities. By firmly placing young people at the core of its work and seeing them as part of the solution rather than the problem, “The Corner” is well equipped to deal with dilemmas and sensitive issues in constructive ways.

Monitoring and evaluation

A multi-agency charitable board manages “The Corner”. The 13 full-time equivalent staff in the multidisciplinary team are employed either by Dundee City Council or NHS Tayside, depending on their professional background.

The service manager conducts the day-to-day running of “The Corner”, which includes recording service usage and monitoring target group usage and trends in issues raised during the drop-in and other activities.

Internal monitoring and evaluation is undertaken in a variety of ways, through:

- a web-based monitoring system which gathers statistical data on service users, specific feedback focusing on topics addressed during a consultation and comments about the service received, suggestions for change and time-limited, issue-based consultations;
- pre- and post-evaluations for preventative issue-based sessions or series of sessions;
- individual support for target-setting and interim and final reviews;
- feedback opportunities for external agencies; and
- annual reports detailing progress.

External monitoring and evaluation is also undertaken in a variety of ways:

- as part of national inspection processes
- as part of accountability to funders
- through external evaluation reports undertaken by an independent evaluator.

Service uptake

The high number of young people accessing the services of “The Corner” provides an indication of its relevance to young people’s lives. Since 1996 there have been 120 000 contacts, with 250 new contacts per month. Figures for the year 1 April 2008 to 31 March 2009 were:

- total contacts: 7649
- total sexual health contacts: 4964.

“The Corner” delivers its services as part of national and local sexual health strategies.

The Scottish Executive launched its strategy and action plan for improving sexual health, *Respect and responsibility (2)*, in January 2005. The Tayside sexual health and relationships strategy, developed by NHS Tayside and community planning partners, was endorsed by the health board in November 2005. Its final recommendations and action plan were informed by the views of local people and were based on best practice, as well as professional opinion. The action plan set out six strategic aims:

- promote a positive and open culture towards sex that is based on the principles of self-respect, respect for others and strong relationships;
- increase support for parents and carers so that they can play a central role in guiding and supporting their children in developing a responsible approach to sexual health and relationships;
- reduce the incidence of unintended pregnancies and the rate of sexually transmitted infections (STIs);
- build capacity across clinical services and increase access to specialist sexual health services;
- improve strategic and clinical leadership and governance; and
- reduce health inequalities and make sure that the needs of vulnerable groups are met.

Specific actions underpin each of the strategic aims. Copies of all the national and local documents can be accessed at <http://www.sexualhealthtayside.org>.

In early 2008, the Scottish Government carried out a review of *Respect and responsibility* that led to the publication of new national sexual health outcomes in September 2008. These call for action by the government, health boards and local authorities and focus on four key areas:

- knowledge and awareness
- leadership
- coordination and performance management
- standards and service provision for young people.

It also sets out a number of long-term outcomes for improvement which include:

- reduced levels of regret and coercion;
- reduced levels of unintended pregnancy, particularly in those under 16, and a reduction in the number of repeat abortions at all ages;
- reduced levels of STIs, recognizing that an increase will initially be seen due to increased testing (case finding);
- increased access to sexual health information and uptake of services;
- reduced levels of HIV transmission, particularly among men having sex with men (MSM); and
- reduced levels of undiagnosed HIV, particularly among MSM and African immigrant populations.

The local multi-agency sexual health strategic group carried out a review of progress at the end of 2007 and identified a number of areas that needed more emphasis. These include:

- more effective sex and relationships education through the extension of peer-led education approaches in schools and community settings and further training for teachers;
- increased provision of seven-day access to sexual health information, advice and services in or nearby secondary schools;
- use of social marketing techniques to engage with young people, especially those in at-risk groups, to better understand their views and influences on behaviour and what interventions would be most effective, particularly before young people become sexually active;
- increased outreach work with at-risk groups in conjunction with existing community initiatives;
- provision of practical support for parents and families to prevent risky behaviours and to strengthen family relationships; and
- increased uptake of long-acting reversible contraception.

The service provided by “The Corner” is respected and valued by young people. It is well known for offering comprehensive information and has pioneered a model of multidisciplinary practice. All of this is now viewed as part of the overall success of “The Corner”.

What young people say

Young people’s views, gathered as part of a series of evaluation opportunities, offer an insight into “The Corner” from a service user’s perspective. Some of these views are shown in Box 1.

Box 1. Young people’s views of “The Corner”

“I’d be too embarrassed to go anywhere else.”

“They’re not looking down on you – it’s not like other places.”

“... you could be in for anything, without everybody knowing what you’re in for.”

“I think that I can confide in staff working at The Corner and they gave me all the information I needed.”

“Had a two-hour wait before I was seen. Was offered an alternative but chose to wait.”

“I was a little embarrassed at first, however, it’s not as bad as I thought it would be.”

“The service I received today was excellent and put me completely at ease. Thank you.”

Youth-friendly services

Work from the Department of Health in United Kingdom (England) suggests that adolescents, who are developing patterns of service use that they will in all likelihood pursue into adulthood, are more likely to seek professional support if their early experiences of services are positive.

Primary health care remains one of the most accessible and available provisions through which young people can access a wide range of health services. Young people consistently report barriers to accessing primary health care services, such as:

- concerns about confidentiality
- lack of information about services
- unfriendly environment and staff
- language barriers (staff use jargon or overly “adult” language) (3).

Recommendations encouraging the removal of these barriers have been complemented by WHO, and this has led to a call for the development of youth-friendly services worldwide.

Health service link worker (young people)

The health services link worker (young people) post was created in 2001 at “The Corner” to work with front-line health care staff and ensure delivery and development of services that are appropriate for, and accessible to, young people. The role is managed and supported by “The Corner” and has a direct partnership link through Dundee community health partnership to the public health practitioner responsible for children and young people.

One of the objectives is to develop youth-friendly practice within primary care settings. In addition to the delivery of awareness-raising training sessions, the health service link worker is involved in supporting practice nurses and general practitioners (GPs) in the creation of a young people’s advisory group for the development of youth-friendly services within their practice.

Training

VIEW (Values, rights, confidentiality, the law) training was developed through a partnership with “The Corner”, the peer-education project and young people. The aims of the training are to develop health workers’ awareness of the needs and issues of young people accessing their services and increase the provision of youth-friendly services.

The training has so far been delivered on six occasions to various groups of service providers. The core principles of the training are influenced by the NHS Health Scotland “Walk the talk” initiative (<http://www.walk-the-talk.org.uk/>).

Feedback from young people and service providers, along with evidence from research, seems to suggest that young people’s views of the health service represent a paradox. On the one hand is an awareness that these services are available to them, but on the other is an embedded fear and anxiety among young people about their status within these services.

The VIEW training takes a two-pronged approach to tackling this. It offers a conscious effort to alleviate the anxieties young people may have about accessing health services while also raising health service providers’ awareness of these barriers and issues.

In March 2008, the group won the Young Scot award for health sponsored by NHS Health Scotland in recognition of their work in improving health services for young people.

A recent initiative, 2008/2009

To enable “The Corner” to continue to be relevant to young people’s needs, their involvement in the development of the service was identified in July 2008 as a key area of work for 2008/2009. In August 2008, the “RE-view group” (composed of seven young people) trained for, designed and implemented a peer review of “The Corner” services, undertaking 20 individual interviews with service users from August to November. They also included three specific questions in “The Corner” service user computerized survey (conducted using SurveyMonkey.com technology), which focused on accessibility and satisfaction with services received at “The Corner”. Responses were received from 1827 service users.

The findings from the peer-review exercise were fed back to young people during January and February 2009 through the city centre drop-in centre and via outreach work. Opportunities to make comments and express opinions about confidentiality and ground rules were undertaken as part of a questionnaire in the drop-in and outreach work, with 138 young people giving their views on confidentiality and 171 on “The Corner” ground rules.

Information gained from service users and highlighted elements of good practice informed the development of the action plan for service developments between January and March 2009. This included:

- incorporating the views of others to influence physical redesign in “The Corner” drop-in facility;
- updating the young people’s confidentiality statement;
- reviewing and updating “The Corner” ground rules; and
- promoting a broad range of services provided by “the Corner”.

Box 2 provides quotations from some young people who have been involved in this initiative.

Box 2. Quotations from involved young people

“I’m proud to be involved in this stuff, we’ve given our views, been listened to and won awards – great!”
“It’s been good meeting new people from different groups, I feel happy [because] we’ve made a difference to The Corner and services.”
“It’s been fun and a confidence boost to have your views recognized to make changes.”

Lessons learnt

Over the last decade and longer, “The Corner” management group, partner agencies, service staff and young people have been very clear about the need to continually support and develop the service. The following key learning points have governed the services provided and its approach.

- There is a need to develop and offer quality/meaningful services to young people, and there has to be commitment to, and support for, this aspiration from the outset from all funders, policy-makers and front-line workers
- Young people will use services if they are accessible, friendly, welcoming and offer clear messages about confidentiality.
- Working outside the mainstream need not mean losing professional identity. Integration works best when there are shared values and mutual respect.
- Different agencies bring different expectations and approaches to partnership working, so it can take a long time to build mutual appreciation.
- There has to be ownership by everyone involved, including young people, to develop positive integration.
- Use of diverse, creative and flexible approaches to working with young people and the skills of the multidisciplinary team have been key features of “The Corner’s” success.
- The best judges of what is needed and how good a service is are young people themselves – ongoing consultation is crucial.

References

1. *Convention on the Rights of the Child*. New York, United Nations, 1989 (<http://www.unicef.org/crc/>, accessed 4 September 2009).
2. *Respect and responsibility. Strategy and action plan for improving sexual health*. Edinburgh, Scottish Executive, 2005 (<http://www.scotland.gov.uk/Publications/2005/01/20603/51182>, accessed 26 October 2009).
3. McPherson A. ABC of adolescence: adolescents in primary care. *British Medical Journal*, 2005, 330:465–467.

United Kingdom (Scotland): a review of youth health service provision in Glasgow City – cross-cutting issues

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Executive summary

The aim of this research was to review the current position of youth health services within health improvement in Glasgow City, United Kingdom (Scotland), and to offer suggestions for their future strategic direction.

A range of approaches was used to carry out this review, including interviews, focus groups and workshops with youth health service staff, local stakeholders, young service users and young people not using services. It was also supported by a literature review and a review of youth health services monitoring information.

Key findings include the following.

- Six models of youth health service delivery have been identified, each with benefits and challenges. Most community health and care partnerships (CHCPs) use more than one delivery model. The models are:
 - youth health drop-in service: clinical provision within existing health facilities
 - youth health drop-in service: prevention and education within existing health facilities
 - youth health drop-in service: prevention and education linked to wider youth provision
 - youth health outreach service: universal
 - youth health outreach service: targeted
 - development of mainstream health services.
- There is an inconsistent understanding of what is meant by “youth health services”.
- There are wide variations in the scope of service delivery across the five CHCP areas, but there are examples of good practice across a range of areas.
- Local stakeholders and young service users are very positive about their experience of local provision. Key elements include the friendliness of staff and the provision of health information using fun and engaging approaches.
- There is currently unequal and inequitable access to youth health services across Glasgow City, with large numbers of young people continuing to face real barriers to access. This relates to young people in the general population and vulnerable young people and/or equality groups that may have specific needs.
- Marketing and branding of services is a core and important activity, but there is a lack of consistency in service marketing and no clear “youth health service” branding.
- There are strengths and weaknesses arising from, and relating to, local networks and partnerships. Although there are examples of excellent partnerships, others require to be strengthened. In particular, the relationship between youth health services and sexual health services and youth health services and children’s services.
- There is currently no system for the routine collation of monitoring information across services. There are also difficulties in measuring the impact of youth health services on the health and well-being of young people.
- Young people are routinely consulted by youth health services and have opportunities to influence what is provided by services, but there are very few examples of young people being involved in a strategic way.

Twenty recommendations are given on issues that are common across all of the youth health services included as part of this review. It is suggested that by working together, these recommendations could be addressed in a more cohesive way that avoids duplication of effort and will lead to greater strategic

coordination of youth health services in Glasgow. It is hoped that ultimately this will lead to the development of youth health services that meet the needs of a wide range of young people who live or work in Glasgow.

Introduction

Background

In December 2008, Create Consultancy Ltd. (Create) was commissioned by NHS Greater Glasgow and Clyde to carry out a review of youth health service provision within Glasgow City, United Kingdom (Scotland). Glasgow, with a population of around 580 000, is Scotland's largest city and is the commercial capital of Scotland.

The parameters of the review were youth health services which are coordinated and delivered by local community health and care partnerships (CHCPs). This includes:

- East Glasgow CHCP: services provided under the banner “H4U”;
- North Glasgow CHCP: services provided under the banner “YHS”;
- South East Glasgow CHCP: services coordinated by the health improvement practitioner and services provided under the banner “Health spot”;
- South West Glasgow CHCP: services coordinated by the youth health coordinator and delivered under the banner “The place @ ...”; and
- West Glasgow CHCP: services provided under the banner “Your health @ ...”.

Due to limitations in the scope of the study, a significant number of broader youth health initiatives delivered by partner organizations were not part of the review. This includes youth sexual health services delivered by the Sandyford Initiative (a Glasgow-based service that offers free and confidential advice, information, referrals and support to people of all ages on sexual, reproductive and emotional health) as part of the local hub provision (“The place”). This was partly due to restrictions on the scope of this review and to wider difficulties relating to new monitoring systems used by the Sandyford Initiative. “The place @ ...” is the brand name for all youth sexual health services delivered across NHS Greater Glasgow and Clyde by the Sandyford Initiative, that is, within Sandyford central and local hubs. It is aimed at young people aged 18 years and younger.

This case study describes the key issues that are apparent within service provision across Glasgow City and examples of good practice from local areas.

Aims and objectives

The aim of this research was to review the current position of youth health services within health improvement in Glasgow City and to offer suggestions for their future strategic direction.

The key objectives were to:

- explore and outline the history and development of youth health service provision with the five Glasgow CHCPs;
- explore and describe the range of services offered, any gaps in provision and the “model” of service delivery within each of the CHCP areas; and
- make recommendations based on the review taking into account the needs of young people, geographical coverage and links to other developments both within health improvement and the wider youth health agenda.

Research methods

The review is based on:

- a literature review and supporting information

- monitoring information from local services
- 32 interviews with staff and local stakeholders
- 5 focus groups with 28 staff members
- 14 interviews with 36 young service users
- 7 interactive workshops with 61 young people not using services.

The initial phase of the research included a literature review conducted by the Public Health Resource Unit at NHS Greater Glasgow and Clyde supplemented by information sourced by Create. In addition, each local area provided monitoring information (requested for April 2007 to March 2008) and evaluation evidence, including final year reports. The local documentation was supported by an initial meeting with the identified lead for the youth health service review in each local area.

The main review phase involved a mix of interviews and focus groups with adult stakeholders, which included staff and local partner organizations. The adult stakeholders were identified by the lead in each area for the youth health service review. The number of focus groups/interviews conducted differed slightly from area to area, depending on the extent of service provision. The adult stakeholder interviews were carried out in person or by telephone. Each focus group and interview lasted on average 30–45 minutes.

In addition, young people were engaged in the review process. This included interviews with young people accessing youth health services. All youth interviews were conducted in pairs or threes due to the preference of the participants. In addition, young people not accessing services were contacted via existing youth provision and/or schools and took part in interactive workshops.

Literature review

In addition to the information provided below, a review of the research literature was conducted by the Public Health Resource Unit at NHS Greater Glasgow and Clyde. It explored the barriers which prevent young people from accessing health services and identified approaches that can help young people overcome these barriers. The literature review is provided in full at Appendix 1.

Young people and health: an overview

In Scotland there is recognition that young people have health issues that require specialist support (1–4). It is also widely accepted that the development of youth-specific health services which are equitable, accessible and acceptable to young people are necessary to help reduce the barriers young people face when accessing services (1,5,6).

Delivering a healthy future: the action framework for children and young people's health in Scotland (2) outlines the challenges to improving the health of children and young people in 21st century Scotland. While focusing on the developments that can be made across health services, the action framework continues to advocate a multi-agency approach to tackling children and young people's health issues:

“Only by working together – both within and outwith the NHS – can we make the difference to children's lives that will create the healthier Scotland of the future to which everyone aspires” (2).

There are many issues of concern in relation to young people's health. WHO reports that the leading cause of disease burden in young people in the developed world is mental health disorders (1). The charity Young Minds estimates that up to 20% of young people in the United Kingdom experience some kind of mental health problem at any one time: this is significantly more than those with a clinical diagnosis (7). The reasons for the increase in mental health problems among young people are many and complex, with vulnerable groups such as looked-after and accommodated young people particularly susceptible (8). The increase in youth mental health problems may have come to attention because more young people are managing to access services; however, it may also be reflective of young people's increasing social exclusion and changing family and social structures.

In addition, the web sites of “Walk the talk” (www.walk-the-talk.org.uk), the Information and Statistics Division of the Scottish Government and the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) indicate that there a number of other issues relating to young people’s health and well-being in Scotland:

- a third of 12–15-year-olds in Scotland are overweight or obese;
- teenage pregnancy rates continue to be higher than most other western countries, particularly among young people who live in the most deprived areas;
- rates of Chlamydia in young people have more than doubled in a decade and other sexually transmitted infections (STIs) are increasing;
- smoking rates continue to be relatively high across the population, with approximately one fifth of 15-year-olds describing themselves as “regular smokers”;
- more than one third of Scottish 15-year-olds say that they have used drugs;
- alcohol-related accidents are one of the leading causes of death in young people aged 15–24; and
- suicide is now the biggest killer of young men in Scotland.

It is well documented that the health of children and young people in Scotland is closely linked to whether or not they live in poverty (9). The *Child poverty in Scotland* report (10) estimates that 250 000 children in Scotland live in poverty, with almost one in eight children living in absolute poverty. This is particularly acute within Glasgow.

A recent school-based study of pupils in secondary years 1 through to 4 (S1–S4) in Glasgow City (11) explored a range of issues relating to young people’s health and well-being. This report breaks down information for the five CHCP areas, but across Glasgow, some of the key findings include:

- 26.1% of pupils live in one-parent families;
- 30% of pupils have a family member with a disability, long-term illness or drug or alcohol problem;
- 74% of all pupils were positive about their general health;
- 36% of boys and 34% of girls across Glasgow had high self-esteem and 28% of boys and 32% of girls had low self-esteem;
- 36% of pupils exercised four or more times per week (average duration of more than 30 minutes);
- 34% of pupils said that they had eaten five or more portions of fruit and/or vegetables in the previous day;
- bullying rates ranged from 8% to 20% across different schools in the city (average of 13.1% of pupils had been bullied); and
- 7.5% of pupils indicated that they were aware of the Sandyford Initiative.

These statistics are supported by a wide range of health needs assessments and surveys which have also helped to inform the development of youth health services (12–15).

Health improvement and inequalities work is a key corporate objective for CHCPs in Glasgow City. Communities across the CHCPs and Glasgow City as a whole have very different social circumstances and health outcomes. Differences in income, gender, race and faith, disability, sexual orientation and social class are all determinants of health and are associated with inequalities in health (16). These factors will also contribute to inequalities in access to, and uptake of, services by young people across Glasgow. The Scottish Government report of the Ministerial Task Force on Health Inequalities (9) identifies children and young people as a defined group for actions to reduce health inequalities.

Young people’s health services: guidance and policy

There is currently no explicit definition of a “youth health service”. This is partly due to the range of approaches that have been developed to help improve the health and well-being of young people.

The Scottish Government’s guidance on valuing young people (17) identifies youth-friendly health services

as a core pillar for delivering “national outcome 4”: young people being “successful learners, confident individuals, effective contributors and responsible citizens”. It also recognizes the contribution this makes to other national outcomes. Although this document does not provide a comprehensive description of all delivery approaches, it does outline the critical components of youth-friendly health services as the provision of:

- general health services;
- mental health services;
- support with ongoing physical health problems;
- health improvement measures, including physical activity, healthy eating, drugs, alcohol, smoking and sexual health;
- social marketing approaches;
- measures to increase young people’s influence on health services; and
- measures to tackle health inequalities.

WHO has produced a framework for the development of youth-friendly health services that outlines the policies, procedures and competencies that demonstrate equitable, accessible and acceptable services (1). This document outlines different types of health services that try to reach young people and categorizes them into six groups. This includes:

- hospital-based centres specializing in adolescent health;
- community-based health facilities that target all populations, such as a general practice or family planning clinic;
- school- or college-based health services which focus on preventive and curative services;
- community-based centres that are not health facilities but which offer wider provision such as recreation and sport, literacy and numeracy training;
- pharmacies and shops that sell health products (but don’t deliver health services as such); and
- outreach information and service provision which takes health information and health services direct to young people on street corners, shopping centres, schools etc.

This guidance concludes that although research has clearly established the barriers young people meet in accessing primary care services, the evidence has not been translated into the design of youth-friendly services. Evidence that supports one model over another and/or demonstrates the benefits of youth-friendly initiatives on the health of young people continues to be lacking.

Findings and recommendations

The following findings are based on the review process that has explored the current position of youth health services within five Glasgow City CHCPs.

This section provides an overview of the models being used for the delivery of youth health services and the core issues that have arisen for youth health services across Glasgow.

Models of service provision

Core criteria for mapping youth health service provision were identified. These criteria shaped the interview questions and helped to identify the benefits and challenges of the different models being used. Six models of youth health service delivery were identified. The criteria that were used to explore these models were based on the WHO framework for the development of youth-friendly health services (1) and were as follows.

Range of service provision

The impact of different models on the range of services that can be delivered by youth health services, such as location and venue. Facilities for clinical services and space for group work were key factors.

Marketing and branding

The impact different models have on services' ability to develop awareness and understanding in their client group about location of services, timing of services and the range of services on offer. The impact of static or peripatetic models of service delivery was a recognized factor.

Equity, access and acceptability

The impact of different models on addressing issues that might hinder young people's access and equity to access. Key factors include:

- whether services are free and located in central and accessible locations at times that are convenient for young people;
- a non-judgemental staff approach and the time available to spend with young people;
- services which offer safety, privacy, confidentiality and appropriate methods; and
- whether services provide targeted provision to help overcome barriers faced by specific groups and/or vulnerable young people: this includes young people from black and minority ethnic (BME) communities, young people who identify as lesbian, gay, bisexual or transgender (LGBT), young people looked after and/or accommodated, young carers, young people with additional support needs and young offenders.

Effectiveness of services

The impact of different models on the ability of services to monitor and evaluate the effect of their provision on the health and well-being of young people.

Partnership working (local organizations and young people)

The impact of different models on the development of local partnerships. Do some models enhance partnership working with different types of partners? Do different models of provision enable different approaches to youth involvement and youth consultation?

These criteria helped to identify the benefits and challenges of the different models, but while some models should in theory provide certain benefits, it does not mean that in practice every example of the model is successful in the approach. For example, although in theory static drop-in services are easier to market than peripatetic outreach services, this is not always the case in practice.

The six identified models include:

- youth health drop-in: clinical provision within existing health facilities
- youth health drop-in: prevention and education within existing health facilities
- youth health drop-in: prevention and education linked to wider youth provision
- youth health outreach: universal
- youth health outreach: targeted
- development of mainstream health services.

These models are described in boxes 1–6.

Box 1. Model 1: youth health drop-in: clinical provision within existing health facilities

This youth health drop-in provides prevention and education services alongside clinical provision. A key feature of this model is the provision of "youth-only" health services from static existing health facilities.

General description

The use of existing health facilities enables the service to provide a clinical dimension as well as prevention and education services. The range of services delivered within this model is:

- pregnancy testing
- STI testing
- contraception and emergency contraception
- "C-card" (condom distribution scheme)
- prevention and education group work on a range of topics
- one-to-one advice on a range of topics (in some services)
- health checks (height, weight etc.) (in some services)
- internal referral to counselling and external referral to a wide range of local services, such as training and social enterprise, youth facilities and sport and recreation.

It should be noted that within this model there are differences in the extent of clinical provision: some services offer clinical sexual health services only while others provide a wider range of clinical services (including sexual health).

Examples in Glasgow City

YHS @ Springburn and The place @ Pollok – both aligned to Sandyford Initiative for provision of clinical sexual health services.

YHS @ Maryhill – youth health service with general practitioner (GP) who provides wide range of clinical services.

Challenges

- Limited access across CHCP due to territorialism, transport and identification with local communities (rather than CHCP area).
- Some perceived barriers to access due to location within existing health facilities: concerns around confidentiality and stigma, particularly if considered a sexual health service.
- For some services, additional stigma due to strong association with youth sexual health services.

Benefits

- Range of services provided.
- Provision of health information in variety of ways (one-to-one advice, group work etc.).
- Easier to market as time and location are constant.
- Young people can develop trust with staff prior to accessing clinical component.
- Potential to encourage access by vulnerable and/or equality groups.
- Potential for clearly defined monitoring information (who is accessing, why they are accessing).
- Potential for youth engagement across all levels of involvement.

Box 2. Model 2: youth health drop-in: prevention and education within existing health facilities

This youth health drop-in focuses on the delivery of prevention and education services. As with the clinical drop-in service, a key feature of this model is the provision of "youth-only" health services delivered from static existing health facilities.

General description

The range of services is:

- prevention and education group work on a range of topics
- "C-card" (condom distribution scheme)
- one-to-one advice on a range of topics
- health checks (height, weight etc.)
- internal referral to counselling and external referral to a wide range of local services such as Sandyford sexual health services, training and social enterprise, youth facilities and sport and recreation.

Examples in Glasgow City

H4U @ Baillieston Health Centre (East Glasgow CHCP).

Health spot @ Castlemilk Health Centre (South East Glasgow CHCP).

Challenges

- Limited access across CHCP due to territorialism, transport and identification with local communities (rather than CHCP area).
- Lack of clinical services (despite access to facilities to enable this provision).
- Some perceived barriers to access due to location within existing health facilities: concerns around confidentiality and stigma, particularly if considered a sexual health service.

Benefits

- Provision of health information in variety of ways (one-to-one advice, group work etc.).
- Easier to market as time and location are constant.
- Potential to encourage access by vulnerable and/or equality groups.
- Potential for clearly defined monitoring information (who is accessing, why they are accessing).
- Potential for youth engagement across all levels of involvement.

Box 3. Model 3: youth health drop-in: prevention and education linked to wider youth provision

This youth health drop-in focuses on the delivery of prevention and education services. A key feature of this model is that services are provided from static venues that host other youth and community groups.

General description

The range of services is:

- prevention and education group work on a range of topics
- "C-card" (condom distribution scheme)
- one-to-one advice on a range of topics
- health checks (height, weight etc.)
- internal referral to counselling and external referral to a wide range of local services such as Sandyford sexual health services, training and social enterprise, youth facilities and sport and recreation.

Examples in Glasgow City

H4U @ East End Health Living Centre.

Health spot @ Jenniburn Centre.

Your health @ Drumchapel Community Centre.

Challenges

- Limited access across CHCP due to territorialism, transport and identification with local communities (rather than CHCP area).

Benefits

- Provision of health information in variety of ways (one-to-one advice, group work etc.).
- Easier to market as time and location are constant.
- Potential to encourage access by vulnerable and/or equality groups as well as young people who access mainstream youth provision.
- Potential for clearly defined monitoring information (who is accessing, why they are accessing).
- Potential for youth engagement across all levels of involvement. Development of strong partnership working with wider youth providers and community groups.

Box 4. Model 4: youth health outreach: universal

Peripatetic delivery of prevention and education group work delivered through existing youth provision and mainstream schools.

General description

Wide range of prevention and education group work ranging from established programmes (such as "Baby think it over" and "Emotional literacy") to ad hoc inputs tailored to the needs of youth providers and/or schools.

Examples in Glasgow City

All youth health services across Glasgow City deliver some outreach services via mainstream schools and/or youth services. Examples of where this is the main delivery method (as opposed to running alongside a drop-in service) are:

- youth health services within South East Glasgow CHCP
- Your health @... within West Glasgow CHCP.

Challenges

- Can be difficult to market due to changing time and location.
- Limited range of services provided.
- Difficulty (when only model being used) to establish a trusted brand which young people can clearly identify with.
- Inputs not always associated with youth health service.
- Time and location of provision is dictated by existing provision rather than needs of young people.
- Less well-established monitoring and evaluation approaches.
- Reliant on partner organizations for organization of delivery.

Benefits

- Wide reach and scope in relation to access and equity as services can be delivered across CHCP area.
- Limited stigma as service is delivered to wide range of young people.
- Potential to target vulnerable and/or equality groups who are linked to wider provision.
- Potential to link to existing youth engagement structures.
- Potential for development of strong partnership working with wider youth providers and community groups.
- When used in conjunction with other models (static drop-in), can help marketing of drop-in service.

Box 5. Model 5: youth health outreach: targeted

Prevention and education group work delivered outside mainstream youth provision and/or mainstream schools.

General description

Wide range of prevention and education group work including established programmes such as "Baby think it over", "Emotional literacy" and ad hoc inputs. All of these programmes are tailored to meet the needs of young people.

Examples in Glasgow City

Across Glasgow City there are fewer examples of targeted outreach work taking place on a regular basis and fewer examples of targeted work with vulnerable groups and/or equality groups of young people.

An example of this model is South East Glasgow CHCP, which delivers group work programmes to young people with additional support needs and harder-to-reach young people, such as the "More choices, more chances" group for young people who are currently (or are vulnerable to becoming) not in education, employment or training.

Challenges

- Can be difficult to market due to changing time and location.
- Limited range of services provided.
- Difficult (when only model being used) to establish a trusted brand which young people can clearly identify with.
- Inputs not always associated with youth health service.
- Time and location of provision is dictated by existing provision rather than needs of young people.
- Less well established monitoring and evaluation systems.
- Reliant on partner organizations for organization of delivery.

Benefits

- Wide reach and scope in relation to access and equity as services can be delivered across CHCP area.
- Engagement of vulnerable and harder-to-reach groups.
- Development of strong partnership working with wider youth providers and community groups.
- When used in conjunction with other models (static drop-in) can help marketing of drop-in service to vulnerable young people and equality groups.

Box 6. Model 6: development of mainstream health services

The delivery of prevention and education services through mainstream health services.

General description

The development of youth-appropriate health services. Example within Glasgow City is the "Birthday card" scheme which involves accessing young people through their GP records and encouraging them to attend a health check on their 15th birthday. The young people who attend the health check are provided with a range of information and referred to wider provision if appropriate – this includes youth sexual health services.

Examples in Glasgow City

South East Glasgow CHCP.

Challenges

- Range of services provided limited by location and venue.
- Difficulty (when only model being used) to establish a trusted "youth health" brand which young people can clearly identify with.
- Barriers such as embarrassment and concerns about confidentiality may prevent young people from attending.
- Less well established monitoring and evaluation systems and limited ability to follow up young people.
- Reliant on the willingness of local GP surgeries.

Benefits

- Wide reach and scope in relation to access and equity as services can be delivered across CHCP area.
- Engagement of young people who do not access youth provision.
- Development of partnership working within health services.
- Can be marketed within GP surgery via posters and leaflets.

Youth health services in each CHCP area are delivered using one or more of the above models. For further information on the extent of local provision, refer to local CHCP youth health service review reports which are available from www.chcps.org.uk and www.phru.net/cyphi/default.aspx.

Recommendations

1. Local CHCPs should use a range of models for the delivery of youth health services.
2. The models of delivery used by local areas should be guided by the identified benefits and challenges aligned to each model and the key issues which have been highlighted within the local CHCP reports.

Common understandings of “youth health services”

The term “youth health services” was frequently used by staff and stakeholders throughout this review, but it emerged that there is no common understanding of what is meant by a “youth health service” and/or what youth health services are trying to achieve. This was apparent among some adult stakeholders but was considerably more pronounced among young people (users and non-users of services).

When asked about the aim of youth health services, adult stakeholders either responded by describing *what* the service provided or *how* it provided this, rather than *why* (what the service intended to achieve in terms of outcome). The most consistent response related to the approach of services (such as accessible or confidential). In some areas, the response included the provision of holistic health services with the general aim of improving the health of young people. Although all services stated that they aimed to explore the wider health and social needs of young people, it was apparent – from adult stakeholders and young service users – that in some areas the delivery of sexual health services is given priority status. This raises a number of interesting questions, not least due to the identification of young people’s mental health within the literature review as an important cross-cutting theme that underpins all health improvement work.

Young people gave a wide range of responses when asked what was meant by a youth health service. Their understanding encompassed services just for young people (youth clubs as well as health services) to services that are established to give young people things to do and/or to provide condoms or other sexual health services.

Overall, young service users had a clearer understanding of what youth health services are trying to achieve in comparison to young people who had not used services. However, service users’ responses varied – not unexpectedly – depending on the type of service they had accessed and their motivation for attending services. Young people who attended drop-in services out of curiosity and/or to socialize with friends were more likely to state the aim of services as giving young people places to go, but young people who attended drop-in services for a specific health need were more likely to identify the aim as, for example, improving health or reducing pregnancy risk.

The lack of common understanding among stakeholders of the term “youth health services” and the aim of services raise a number of issues. It is unclear whether specific interventions – particularly prevention and education programmes – in use by youth health services are evidence based because there is a lack of clarity on what these programmes aim to achieve. It is apparent that some young people (particularly young non-users of services) are unclear about what youth health services provide and what they can expect if they access a youth health service. This issue is particularly significant due to the importance young people place on being able to trust and develop meaningful relationships with services. There is also a lack of clarity in some areas on how youth health services differ from youth sexual health services and/or how youth health services can clearly distinguish themselves as offering more than sexual health services. Finally, the lack of clearly defined outcomes makes it difficult to assess whether youth health services overall are successfully achieving what they intend to do.

A number of features appeared to help the understanding of what is meant by youth health services and what

they aim to achieve among stakeholders and young people. These include:

- well-developed local networks (stakeholders)
- strongly developed brand (stakeholders and young people)
- continuity of staff across different types of provision (young people).

Recommendations

1. Youth health services would benefit from having a shared definition of what is meant by “youth health services”. This should include greater clarity on how youth health services differ from topic-specific services and/or a clear rationale explaining why some health topics are given greater priority.
2. Youth health services would benefit from having clearly defined and measurable outcomes and a clear understanding of how their service provision and approach are designed to achieve these outcomes.
3. At the very least, it would be useful for youth health services to have an explicit and shared understanding of the assumptions that are being made about how their services and model of service delivery achieve the outcome of “improving young people’s health”.

Equal and equitable access?

Both within and across CHCPs in Glasgow City, it is evident that youth health services are not delivered in an equal or equitable way. This is partly due to the way local youth health services have developed and the funding that has been allocated to their development within local areas. In areas where youth health has historically been a priority (north Glasgow and east Glasgow), youth health services are more established and offer wider-ranging service provision. The lack of equal and equitable services can also be partly attributed to the lack of strategic direction provided. This is most apparent in relation to the balance between the delivery of universal and targeted services and also in the location of drop-in services.

There is some universal provision in each CHCP area, but the form differs considerably. There is not currently a drop-in youth health service in all CHCP areas and even fewer areas have drop-in services with a clinical component. Within CHCP areas with one or more drop-in service, there is recognition that because of the size and geographic spread of CHCPs, many young people living within the CHCP will still not access provision. This is partly attributed to territorialism but wider issues such as community identity also play a part: for instance, young people living in the Glasgow City area of Bridgeton do not consider services in Baillieston, approximately four miles (6 km) distant, as “local”.

The decision on where drop-in services are located was often based on preferences identified by young people in local needs assessments, but in other instances it was governed mainly by practicality (the availability of venues, flexibility on what can be offered, link to Sandyford hubs, etc.). In some areas, stakeholders and staff reflected on the fact that needs assessments, which led to the establishment of services, had been carried out over eight years previously within different local administrative health structures. This was considered problematic due to the time frame and also the change in areas encompassed by the different health structures.

All youth health services across Glasgow City deliver youth health outreach services predominately through youth organizations and mainstream schools. The delivery of youth health outreach through schools is viewed as a particular strength of youth health services as it enables contact with a large number of young people, many of whom are from areas of socioeconomic deprivation. In addition, the delivery of youth health outreach through existing youth provision is seen as a proactive way of overcoming territorialism while also helping to build the capacity of local youth work staff. This was perceived as a particular benefit due to the limited staff capacity within dedicated youth health services and the recognition that improving young people’s health is the responsibility of all services, not just dedicated youth health services.

Although it is evident that youth health services are reaching varying proportions of young people in their target areas, all types of respondent in this review recognized that many young people are not accessing services. The most common “missing” group identified by stakeholders was young people from minority

ethnic communities and young people from specific geographic locations (often where there are no drop-in services). The needs of vulnerable young people and young people from other equality groups were, however, conspicuous by their absence in stakeholder discussions on missing groups and barriers to access. This may indicate a lack of awareness around the needs of vulnerable young people and those from equality groups (such as those who identify as being LGBT, young people in care, young offenders or young people with additional support needs), and a lack of clarity as to whether youth health services can meet their needs.

As the needs of vulnerable and/or wider equality groups did not feature in many stakeholder interviews/focus groups, there was also no full discussion as to whether current services can meet the needs of these young people. Despite this, some wider questions can be asked, such as: could the needs of vulnerable and/or equality groups be met through better consideration of how services are marketed? Would slight adaptation to existing provision help to meet needs? Or are the needs of some young people so specific as to require a completely different model of service?

Recommendations

1. Youth health service provision across Glasgow City would benefit from a strategic plan that provides guidance on minimum levels of youth health service provision within each CHCP area.
2. The development of clear outcomes and clarification of the assumptions underpinning service provision which seeks to achieve these would help youth health services provide a rationale for how services are developed. For example, defining outcomes more clearly would help local youth health services identify which model of delivery would meet identified local need.
3. Youth health services should have a clear rationale on the balance of delivery in relation to universal services and targeted provision.
4. Future discussion about the development of equal and equitable access to youth health services should consider:
 - advantages and disadvantages of different delivery models;
 - costs associated with different delivery models;
 - minimum levels of needs assessment/youth involvement prior to developing new services;
 - whether the needs of young people from minority ethnic communities and other equality groups are fully understood and whether youth health services are best placed to meet their needs; and
 - whether the needs of vulnerable young people are fully understood and whether youth health services are best placed to meet their needs.

An example from practice is shown in Box 7.

Box 7. Example from practice

Youth Health Services (YHS) operates from Maryhill and Springburn health centres and covers North Glasgow CHCP. YHS @ Maryhill offers 12–19-year-olds a confidential drop-in service where they can see a nurse or doctor, take part in workshops, talk to counsellors or youth workers or workout in the gym.

YHS aims to support young people with any immediate health problem and help to prevent long-term conditions, many of which are attributed to lifestyle choice, such as smoking or engaging in unprotected sex. In the longer term, YHS aims to support young people who are struggling through their teenage years and to connect them to hobbies, training or education opportunities. “Maxine” describes her experience of YHS.

“I first went to YHS three years ago and I have been in and out for different things. I got to know Julie who got me involved in Creative Pathways, an arts-based programme where you design and make clothes from recycled garments from charity shops. After six months we put on a fashion show which was fantastic! Now I’m at north Glasgow doing fashion and design. I just never thought I could do anything like this.”

Marketing and branding

Marketing and branding were identified as critical to the success of youth health services, but the difficulty

in marketing and maintaining the profile of youth health services was also recognized. Within this review, many examples of how local youth health services market their services were identified. These include:

- direct inputs to young people through schools and youth provision;
- street work;
- social networking (such as Bebo pages and Internet sites);
- leaflets and posters in a range of settings (including mainstream health services);
- raising awareness among local youth organizations through local networks and partnerships; and
- use of marketing materials such as rulers, pens and mouse mats.

It was stressed that marketing can be time consuming and requires to be carried out in innovative ways because young people do not always respond to leaflets or posters.

The important role of schools in raising awareness of youth health services among large numbers of young people in Glasgow City was identified by all stakeholders, including young people. Another important approach to marketing was local youth providers raising awareness among young people who attend their services. There are many examples of workers accompanying young people to youth health drop-in services on their first visit.

It is clear from staff delivering youth health services that marketing is time consuming, so they need to maximize all marketing opportunities. This includes the development of a strong brand that helps young people clearly identify their local youth health service. Areas with a strong identifiable brand across all aspects of their provision seemed to improve awareness among non-service users. In addition, it was suggested by adult stakeholders that it helps young people to make the links between different types of provision (such as a person delivering group work in school being linked to the youth health drop-in).

There are different brand names across Glasgow City under which youth health services are marketed. This is confusing and makes it difficult to recognize links between youth health service provision in local areas. It is also costly in terms of the design and printing of a variety of brand images and marketing materials.

Barriers to the marketing of youth health services were identified as limited capacity within youth health services and the need to make services relevant to the needs of young people. It was also evident that some areas face specific barriers to marketing their service (particularly in schools – mainly denominational) because of the association between youth health services and youth sexual health services. This was not universal, however, and some drop-in services that provide (either now or historically) clinical sexual health services successfully engage and market their service in schools, including denominational ones. Often this is because they focus on wider components of their provision, such as prevention and education group work, direct access to counselling or “someone to talk to” about any health issue. In other instances, it was because they had established relationships for the delivery of prevention and education group work within the school, such as an emotional literacy programme.

The youth health services that reported the greatest barriers to carrying out their marketing via schools were those that are closely aligned to the Sandyford hub provision and are branded under “The place @ ...” banner. “The place @ ...” is the brand name given to all youth-specific Sandyford sexual health services. In some areas, however, close partnership working has enabled the local hub provision to develop from being a sexual health service to providing broader youth health services. The main problem is that this distinction is not clear from the brand name alone.

Recommendation

1. It would be valuable for youth health services across Glasgow City to develop one common brand name that enables all services to be clearly identifiable. Where services are marketed under the brand of “The place @ ...” it is not clear to young people or the wider population whether they are sexual health-only services or youth health services. The development of a common brand name for youth health services would help this confusion.

An example from practice is shown in Box 8.

Box 8. Example from practice

The “H4U” brand was developed in East Glasgow CHCP following a large-scale competition that encouraged local young people to develop a name, logo and image for their new youth health service.

H4U branding is used consistently across all aspects of their service provision in youth health drop-in and outreach services. The range of branded materials includes pens, mouse mats, staff clothing, posters and leaflets.

The branding of staff clothing enables young people to clearly identify staff irrespective of where services are delivered.

Local networks and partnership working

Partnership working was identified by stakeholders as something they currently do well, while simultaneously being an area of working that they felt would benefit from some consistency and guidance across the services. The important role of partner organizations was clearly recognized. This included in-kind support in terms of staff time and/or facilitating or taking part in marketing activity.

The review highlighted that across Glasgow City, the most established relationships of youth health services are with wider youth provision and schools. This is particularly evident in CHCP areas with well-developed youth/youth health networks and youth practitioner structures where young people’s health is an identified priority issue for the local area. Despite examples of excellent partnership working and well-developed local links across Glasgow City, however, there is no consistent approach to how youth health services work with partner organizations, including schools and statutory youth provision. Often the approach to working is due to relationships between individuals rather than strategic or service-level agreements at Glasgow City or CHCP level. This has led to situations where a partnership approach for the delivery of youth health services is agreed and implemented in one part of the city, while a similar partnership approach appears unachievable in another.

It was interesting to note that there were no references to local networks (or Glasgow-wide groups) established to meet the needs of vulnerable young people or equality groups. This may link to the previous points regarding youth health services not being aware of the needs of these groups and whether youth health services are best placed to meet their needs.

A number of issues arose relating to the link between youth health services and wider National Health Service (NHS) and CHCP provision – particularly the Sandyford Initiative, a key service provider of youth sexual health services. It is recognized that in some areas, there are excellent links between CHCP youth health services and the Sandyford Initiative youth sexual health services. Within two CHCP areas, the youth health drop-in services are aligned to “The place” and are based within the Sandyford hub. In other areas, however, the relationships between youth health services and the Sandyford Initiative are less well developed or less positive, and more constructive partnership working would be beneficial. There is a number of reasons for the less-positive relations, including changes in staff personnel and key roles being unfilled (or a staff member being absent) for long periods of time, but the historic development of youth health services and the emergence of Sandyford hubs is an important factor behind relations in some areas.

It would seem that in areas with good partnership working between youth health services and the Sandyford Initiative, the relationship pre-dates the emergence of the CHCP structure and the Sandyford hubs. In addition, there is greater clarity on the role and scope of what youth health services and what the Sandyford Initiative provide. In the two areas where youth health services are delivered jointly, the role and scope of the local CHCP staff and Sandyford staff (as well as other local contributors) has been clearly defined as part of a service-level agreement.

This differs from other areas, where the relationship between CHCPs and the Sandyford Initiative was more formally established after the emergence of CHCPs and the Sandyford hubs. Some staff and stakeholders described being frustrated at the lack of flexibility around local negotiation on the location of youth health services, if they wanted to offer a sexual health clinical component. This is because of the requirement for youth sexual health services to be delivered as part of the Sandyford Initiative hub provision. In some areas, youth health drop-in services had historically delivered a clinical sexual health service but do not provide this currently. There was some frustration that this aspect of their provision had been removed due to the emergence of the Sandyford hub. There was a lack of clarity on the reason why youth health services could not continue to offer a clinical sexual health service even if the CHCP area also has youth sexual health services delivered as part of the Sandyford hub. This is particularly true in areas where the hub is not easily accessible to everyone within the CHCP area due to location.

There are few examples across Glasgow City of youth health services directly linking to mainstream NHS services and/or wider CHCP services. The reasons for this were not clear, but it was widely recognized as a core factor that needs to be addressed in order to ensure the ongoing equitable delivery of youth health services. A recurring theme was the need to strengthen links between youth health services and children's services. Youth health services are planned within the "health improvement" structure of CHCPs, whereas children's services are under the "children's services" planning structure of CHCPs. The implications of the separate planning structures seemed to be no formal links between the planning and development of children's services (which includes planning for some of the most vulnerable children and young people) and youth health services. This meant that opportunities for joint working and ensuring that the most vulnerable groups of children and young people are aware of youth health services were not taken.

Many adult stakeholders indicated that the widening of children's services to incorporate children and young people aged 0–18 years (rather than predominately 0–5, as had previously been the case) presented a future opportunity for youth health services to develop better links with children's services planning. This would help to generate stronger links with social work and specialist services that work with hard-to-reach and vulnerable young people.

Recommendations

1. Youth health services would benefit from closer planning at a strategic and practitioner level with wider CHCP services – particularly children's services and city-wide services such as the Sandyford Initiative.
2. Youth health services recognize and value their close partnership working with local organizations, including schools and youth providers. This would be aided by well-developed local strategic and practitioner networks and recognition among local agencies that young people's health is everybody's business.

Examples from practice are shown in Box 9.

Box 9. Examples from practice

"Your health @ ..." was developed to address the lack of youth health services within West Glasgow CHCP. It is a peripatetic service that works in conjunction with existing youth provision and schools to deliver a range of healthy activities and prevention and education group work.

This delivery model was developed following the active involvement of local voluntary and statutory organizations who recognized the importance of developing youth health services based on the identified needs of local young people.

Across the west, practitioner networks have been established to discuss and identify the needs of young people and help to develop equitable access to a range of services that can support young people's health

and well-being. As a result of these networks and the evidence available, a working group was formed to ensure youth health services were developed.

“The place @ Pollok” is delivered as part of youth health service provision in South West Glasgow CHCP. The clinical drop-in service is a partnership approach involving the CHCP, Sandyford Initiative and local youth organizations.

Although the clinical service has a focus on sexual health services, the wider partnership enables the needs of young people to be considered in a holistic way. The following story provides an example of this.

“Adam” went along to regular group work sessions on alcohol. Later, during a one-to-one session with the nurse, he disclosed that he was concerned about his alcohol use. The nurse was able to discuss this with him, informing Adam about how alcohol could impact on his life now and in the future. The nurse went on to refer Adam to the alcohol worker within the youth health service. Adam attended one-to-one sessions with the worker for support with his alcohol use. As a result, Adam reported being able to take part in activities while drinking less alcohol. Adam is now a great advocate for the service and regularly brings new friends along.

Youth consultation or youth involvement?

Youth health services across the city have well-established youth consultation approaches, but a contrasting lack of strategic youth involvement structures. Throughout this review and across all the youth health services examined, there were excellent examples of young service users being consulted and asked their opinions on an ongoing basis about the services they receive. Stakeholders and young service users were able to give examples of how the views of young people had shaped the delivery of youth health services. This often related to the delivery of prevention and education group work and/or the provision of additional services within youth health drop-in centres, such as stress reduction techniques.

There was also recognition across youth health services that services have been developed and shaped in response to large-scale needs assessments. This and the ongoing focus on youth consultation led staff and stakeholders to describe an ethos of youth-led service provision. Despite this ethos, there were few examples of well-established systems for the ongoing involvement of young people at strategic level. The lack of strategic involvement was identified as a gap in two CHCP areas (both areas are currently involved in the development of newly formed strategic youth involvement structures). Other stakeholders indicated that current measures that focused more on the ongoing consultation of young people were sufficient. This is reflective of a wider ongoing debate about how best to involve young people in service delivery and whether involvement structures are truly any better at enabling young people to influence the direction of service than more basic consultation.

Much of the literature (18) suggests that no single approach is correct, but methods must be chosen to suit the needs and priorities of those involved, the resources available and, where relevant, must ensure that all young people have the opportunity to get involved. There is broad agreement that a range of methods for the engagement and involvement of young people should be used by service providers. There is a number of ways of describing different levels of participation; these have commonly been represented in terms of a ladder (19) (Fig. 1). The “ladder of participation” shows the different types of participation. Although presented as different levels, the model does not assume that (beyond the non-participation rungs) the maximum level of participation is always appropriate or the most beneficial.

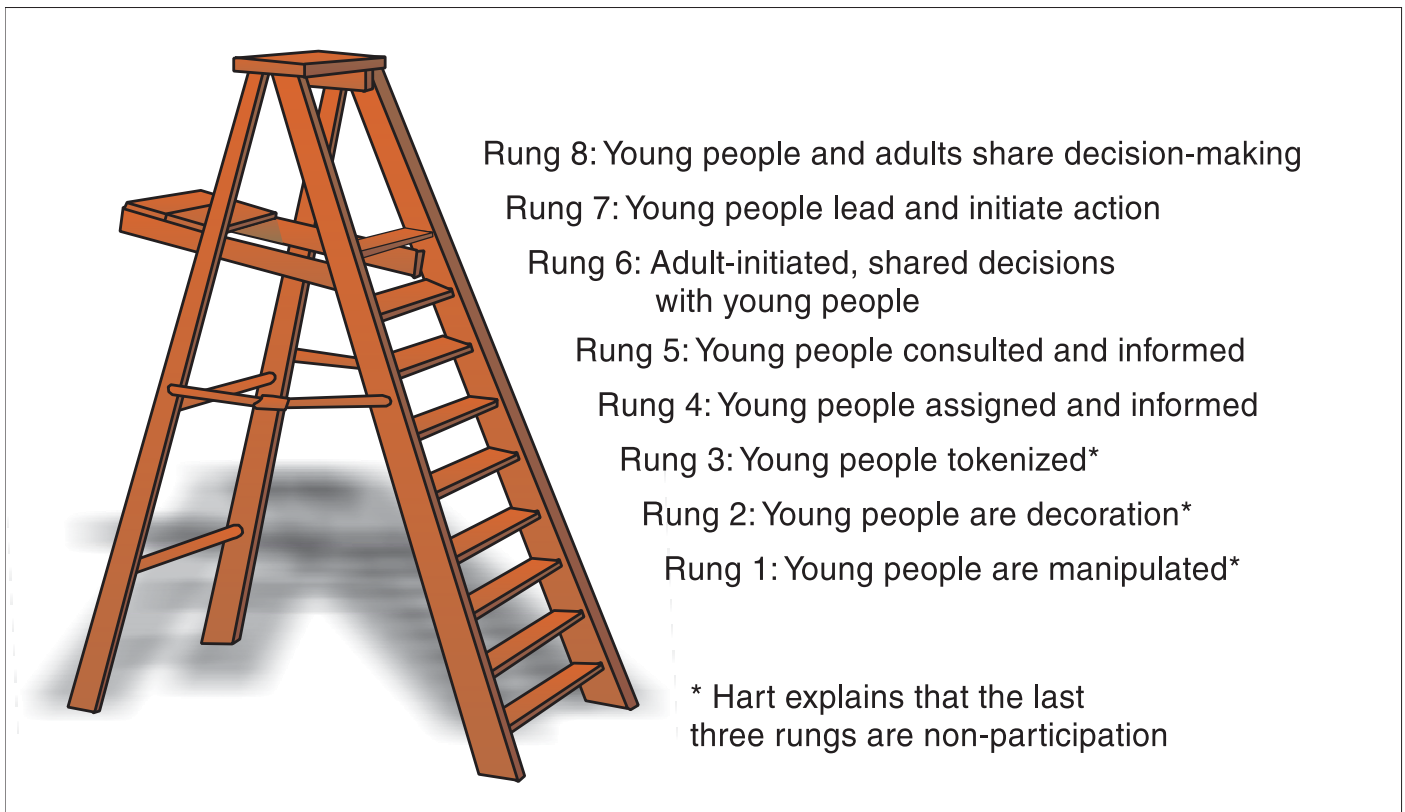


Fig. 1 Hart's ladder of young people's participation (19)

Recommendation

1. Youth health services should consider whether the current levels of youth participation, with a focus on consultation, are sufficient for ensuring that services are youth-led. In considering this, it would be useful to focus on the following.
 - Whether youth health services need to involve young people in more ways and whether more strategic youth involvement would be beneficial for young people, youth health services and/or the CHCP/NHS Greater Glasgow and Clyde.
 - Whether youth health services require to develop their own youth involvement structures or whether the development of youth health services can be sufficiently influenced by community planning partnership (CPP), CHCP, and/or Glasgow City-wide youth involvement structures if and where they exist. If these structures do not exist, would youth health services be better served by supporting their development rather than creating their own?
 - The resources required to sustain meaningful involvement should be recognized.

An example from practice is shown in Box 10.

Box 10. Example from practice

As part of a wider review of youth health services, South East Glasgow CHCP recognized that youth involvement structures are lacking in the local area. Due to this, a number of structures are being developed:

- capacity building of 27 young people from across local schools to develop “youth action” and “health action” groups: it is hoped that these groups will ultimately become the youth involvement strand of the public partnership forum of the CHCP; and
- development of a “youth bank”: this will be part of the CHCP structure but with support from a wider partnership steering group, enabling young people to control a budget and award small grants to innovative practice across the community.

Although not fully formed, it is hoped that by supporting and developing local structures young people can be meaningfully involved in the ongoing development of services, including youth health services.

Measurement and evaluation

There is currently no consistent collation of monitoring information across Glasgow City youth health services. The information that is collated differs from CHCP to CHCP, across different organizations within the same CHCP and also within individual youth health services, depending on the type of service provided.

Overall, monitoring information was more robust for drop-in services than provision delivered as part of outreach programmes. The information collated across CHCP drop-in services includes age, gender, post code/area of residence and reason for attendance. It does not always include ethnicity or disability. For outreach programmes, the information varies enormously but generally includes the total number in attendance and gender of those attending.

All areas have well-established mechanisms for immediate user evaluation of prevention and education group work programmes and for exploring young people's views on how youth health drop-in services are delivered. This includes the use of paper questionnaires/satisfaction surveys, "youth comments" notice boards within drop-in services and, in one instance, the online questionnaire service Survey Monkey.

Staff and stakeholders across Glasgow City felt that youth health services were having some impact on the health and well-being of young service users, but they could not be sure of the extent of this impact: the impact is not adequately measured, and many perceived/intended benefits would either not be seen until later in life or were "softer" outcomes that could not be captured by statistics or prevalence rates.

This raises a number of issues regarding how well supported youth health services are to measure and collate information that could help to demonstrate the impact of their provision. This is important to help ensure the effectiveness of, as well as ongoing funding and long-term sustainability of, youth health services.

Recommendations

1. Youth health services would benefit from a consistent and agreed approach for the collation of monitoring information for drop-in and outreach services.
2. Youth health services would benefit from the development of outcomes that are clearly measurable. This would be further aided by clear guidance and top-level evidence on "what works", including evidence-based prevention and education programmes, evidence for the prevention of teenage pregnancy and evidence for the development of positive mental health.
3. Youth health services would benefit from a systematic central collation of baseline figures and yearly monitoring statistics from all youth health services. This would help to measure the impact of youth health service provision across Glasgow City.
4. Wider discussion is required on how best youth health services can capture "softer outcomes" such as increased confidence and decision-making.
5. Youth health services will need to explore staff development and support needs around outcome-focused planning and the practical application of monitoring and evaluation procedures.

Strategic direction and guidance

Adult stakeholders identified the need for more strategic working across youth health services in Glasgow City to ensure equal and equitable service provision. This also included enhanced opportunities for the sharing of good practice and a mechanism for Glasgow City youth health services to influence policy direction, as well as to respond to emerging issues and Scottish Government priorities in a coordinated way.

It was identified that the existing Youth Stakeholders Strategic Youth Health Network, which supports youth health developments across Greater Glasgow and Clyde, is one existing structure that could be utilized to provide strategic support and guidance. It was also recognized, however, that although this structure has been in existence for some time, it currently does not provide this support. This is potentially because this network is practitioner-led with no centralized support structure that can coordinate effort and/or disseminate

guidance to all youth health service staff.

Recommendations

1. Youth health services would benefit from a strategic plan that outlines the way forward to help address the issues raised in this review. In particular:
 - to develop outcome-focused planning and a common definition for youth health services;
 - to define how and where future provision is developed (that is, which model(s) of provision, target group, location of services);
 - to support the marketing and branding of youth health services;
 - to develop core monitoring procedures for different types of service provision;
 - to develop evaluation approaches that would enable youth health services to measure “softer” outcomes; and
 - to consider different models of youth involvement and how best local youth health services can engage young people.
2. The form of this strategic support requires fuller discussion, but it is recommended that consideration is given to the development of a post (or specific role within existing post(s)) which would provide dedicated time to develop strategic guidance and provide strategic support to all youth health services within Glasgow City.

Conclusion

In carrying out this review, it became evident that there are examples of excellent practice across all youth health services in which staff, despite a range of barriers (including limited resources, restrictions in location and territorialism) are providing young people with the opportunity to enhance their understanding and commitment to their own health and well-being. It was also evident that in each area, the services that are delivered are widely welcomed by local partners and are appreciated by young service users.

All of the issues raised within this review are common to each of the local CHCP youth health services. The review presents an opportunity for youth health services to move forward based on the objective recommendations presented. If this opportunity is not taken, it is likely that each local area will try to solve the problems identified in their own individual reports separately. This would take significant time and would constitute a considerable duplication of effort compared with seeking to address the broader issues together across all five CHCPs. The development of youth health services across Glasgow City would benefit from trying to achieve the same goal and through shared best practice in a supported and coordinated way. The best approach to achieving this requires further discussion, but it could include a pan-Glasgow City representative body with commitment to developmental time from each CHCP area. This would enable working groups to be developed from across services in relation to the core recommendations.

It is important to emphasize that the recommendations in this report will need to be considered alongside wider developments, including ongoing structural changes within CHCPs, Scottish Government priorities and targets and policy documents and national guidance such as *Valuing young people (17)*.

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References

1. Tylee A et al. Adolescent health 6: youth-friendly primary care services: how are we doing and what more needs to be done? *The Lancet*, 2007, 369:9572:1565–1573.
2. *Delivering a healthy future: an action framework for children and young people's health in Scotland*. Edinburgh, Scottish Executive, 2007.
3. *Bridging the gap: health care needs of adolescents*. London, Royal College of Paediatrics, 2003.
4. *Walk the Talk. Developing appropriate and accessible health services for young people: a guide for practitioners and managers*. Edinburgh, Scottish Executive, Fast Forward Positive Lifestyles Ltd and Community Learning Scotland, 2000.
5. Furlong A, Cartmel F. "You get people to talk to and that." *An evaluation of three youth health services in Glasgow*. Glasgow, NHS Greater Glasgow and Clyde, 2006.
6. Dowds J. *CPR: young people's barriers to accessing health services*. Clydebank, Clydebank LHCC, 2002.
7. Green H et al. *Mental health of children and young people in Great Britain. Summary report*. London, Office for National Statistics, 2004.
8. Richardson J, Lelliot P. Mental health of looked after children. *Advances in Psychiatric Treatment*, 2003, 9:249–256.
9. *Equally well: report of the Ministerial Task Force on Health Inequalities*. Edinburgh, Scottish Government, 2008 (<http://www.scotland.gov.uk/Publications/2008/06/25104032/0>, accessed 10 November 2009).
10. Scottish Affairs Committee. *Child poverty in Scotland: third report of session 2007/2008*. London, The House of Commons, 2008.
11. *School survey: health and wellbeing of S1–S4 pupils in new learning community schools in Glasgow*. Glasgow, NHS Greater Glasgow and Clyde, 2008.
12. Dowds J, Roshan N. *Talking the walk: Greater Glasgow's response to young people's health service needs*. Glasgow, NHS Greater Glasgow, 2004.
13. Cooper M. *Counselling in schools project: evaluation report*. Glasgow, Counselling Unit, University of Strathclyde, 2006.
14. *Executive summary: the sexual health and relationships of young people in Glasgow*. Glasgow, FMR Research, 2006.
15. *Qualitative consultation with young people in the City of Glasgow on sexual health and relationships*. Edinburgh, Progressive Partnership, 2006.
16. Acheson D. *Independent inquiry into inequalities in health report*. London, The Stationery Office, 1998.
17. *Valuing young people: principles and connections to support young people achieve their potential*. Edinburgh, Scottish Government, 2009.
18. *Hear by rights: standards for the active involvement of children and young people*. Leicester, National Youth Agency, 2005.
19. Hart R. *Children's participation from tokenism to participation*. Florence, Innocenti Research Centre, 1992.

Appendix 1. Young people's health services research and good practice: a note on evidence

This review is based on literature retrieved through a series of tailored literature searches by a professional information specialist. Many studies do not conform to accepted standards of high-quality evidence. Systematic reviews specific to youth health services are few, although a number of protocols for further work have been developed recently. Veerman & Yperen (1) characterize youth health services as being evidence-informed rather than evidence-based and highlight the difficulties this presents for those planning and implementing services. They present a useful discussion around the assessment of evidence, suggesting a four-stage model, each providing a different degree of certainty of effectiveness. Quality assessment standards are currently under discussion in the NHS Greater Glasgow and Clyde Public Health Resource Unit with a view to establishing agreed criteria for use in evidence reviews.

Literature on youth health services explicitly acknowledges that young people experience a range of barriers preventing them from using health services effectively. Encouraging wider access entails a range of strategies, with improving information, tailoring services to the specific needs of this age group and ensuring confidentiality being key (2). Discussion of services in the United States reaffirms knowledge of the barriers, including the relationship between clients and staff: "quality, style and expertise of the physician" is crucial and teenagers reportedly seek warmth, compassion and good communication skills in preference to a health professional who is young.

A United Kingdom survey (3) supported the primary need for good communication but noted that the young participants placed more emphasis on the youthfulness of the professional than on the acceptable image of the service venue. In the United States, the problem of confidentiality is compounded by the fact that young people do not generally have independent health insurance, so a visit to the family physician often requires parental permission, a barrier to service use that is shared across the continents. As in the United Kingdom, consultation time in primary care is woefully short and does not inherently provide a supportive environment that allows discussion to move sensitively from presenting to prevention issues.

The lack of appropriate services for young people is related to a poor record of consultation with them. When asked their views on making general practice (GP) surgeries more youth-friendly, teenagers suggested the need for young person-only slots, good practice with regard to confidentiality, the provision of information booklets about surgeries, and general surgery hours with after-school slots for young people (4). Young people expressed difficulty in approaching existing services, often because they simply did not know how they work (for example, what times they were open and their standards of confidentiality). This reflects the idea that well-marketed, specialized youth services could relieve these problems. There was a reported discrepancy between the services felt to be important by providers and those requested by young people: many teenagers wanted more information on general health topics as well as "sex and drugs" (3).

These issues sum up much of the discussions around youth health services to date. Services for teenagers are less likely to attract their target audience if they do not provide appropriate information, assured confidentiality, a sensitive environment and local accessibility.

Primary care/community-based services

In the United Kingdom, the move in the 1990s to locate more health care services in primary care settings raised questions about services for young people. Given teenagers' expressed concerns over anonymity and confidentiality, it was appreciated that primary care services, designed to serve the general population, may not provide the most effective settings to engage effectively with this age group. Collaborative working across agencies offered a new approach.

A collaborative initiative in the late 1990s involved a community health worker and a local practice nurse running structured health promotion workshops with an established group of young teenagers (11–14 years). The young participants were all from a housing estate in a disadvantaged area of Sheffield where an initial

survey found 59% of teenagers to be worried about their health (5,6). Workshop topics were generated by the concerns of the group and included healthy eating, stress management and first aid. The combination of community health worker and practice nurse offered a breadth of experience and a link to the GP surgery if required. There is general consensus that work of this kind moves youth health services in the right direction, but while process evaluation is supportive, robust evaluation findings indicating efficacy are lacking.

Widening access to youth directly through the GP surgery appears to be less effective. A randomized controlled trial reporting on 14–15-year-olds who were invited for a series of individual consultations with their GP practice nurse to discuss their health behaviour concerns suggested that this made only minimal impact on their service use, although at the end of the project, 90% of the youngsters reported finding the consultations useful (7).

A study of 13–17-year-olds in urban Canada showed that they did not regard their family physicians as having a health promotion role and relied on them for biomedical advice only. In choosing who to speak to on matters of personal health, it was important to the teenagers to trust and be comfortable with that person; a wide range of people were cited as possible confidants on health matters, including physicians, teachers and parents (8). Overall, these young people were less concerned with prevention than with modifying their current health behaviours in relation to direct personal experience.

More recently, an Australian study offered robust findings which showed that young participants consulted GPs mostly for somatic complaints and that a substantial number expressed fear that their problem was life-threatening. Fewer of the young people presented with a mental health issue than those who, during the consultation, expressed concern that they had one. This suggests poor self-assessment of mental health status, possibly due to lack of knowledge and/or lack of awareness of the role of the GP in relation to mental health and the treatment options available (9). In conclusion, the study suggests that GPs are well placed to assess young people's "fears, expectations, and perceptions of their mental and physical health" and "to provide appropriate guidance" (9).

An environment of trust is at the heart of effective youth health services. For many, this can only be found away from links with the parental home, school or the GP surgery. Research results from the United Kingdom (10) prioritized the establishment of good client/GP relationships over confidentiality and challenged the notion that teenagers find concerns over confidentiality inhibit their use of primary care services. Community-based drop-in clinics offer an alternative, but it is important that such clinics are flexible to the needs of young people, are developed in consultation with young people, and link in to other local services. Internally, staff must be clear of confidentiality guidelines and responsibilities (11).

One community-based approach adopted with young people aged 12–21 years from low socioeconomic areas in the United States was designed to address high rates of STIs among youth (12). It consisted of three interactive skill-building workshops offered through community-based organizations and was designed to encourage health-seeking practices through the development of self-efficacy, positive beliefs and the increase of knowledge and skills. A study of this service indicated positive benefit for females in relation to the scheduling of health checks, undergoing health checks and talking to family and friends about the importance of health checks, but no measurable benefit for males. For males and females, self-efficacy was not improved. It was also noted that participation rates suggested the possibility of attrition bias.

The evidence suggests that primary care settings can play a valuable role in the provision of health services for young people if the services are well-designed to meet the needs of the client group. This role can be enhanced if staff work collaboratively with community or school-based staff. Targeted teenage health clinics within GP surgeries can work effectively if they are well marketed, accessible in terms of hours and location and are sensitive to the need for anonymity and confidentiality (13).

"Communities that care" is a community-based prevention system that "empowers communities to address

adolescent health and behaviour problems through a focus on empirically identified risk and protective factors”. Reductions in risk factors should impact on substance misuse and delinquent behaviours. It is delivered through six training events delivered over six months to a year and guides are available for community leaders.

Findings suggest that this system results in a significant reduction in initiation of delinquent behaviour among the intervention group, but the research was carried out in small towns and there is no evidence to suggest that it will have a similar effect in larger cities.

Sexual health

The United Kingdom compares unfavourably with the Nordic countries and the Netherlands with regard to sexual health behaviours of teenagers and young adults. At the start of the 21st century, only 50% of young people in the United Kingdom used contraception at first sexual intercourse, compared with 85% in the Netherlands (14). Low teenage pregnancy rates found in these countries have been attributed to the different prevailing culture: this is one that supports openness and communication within families and at the same time views teenage pregnancy as socially unacceptable. Cultural attitudes are reinforced by mandatory and/or high-quality sex education and family planning clinics that work collaboratively with schools (15).

This echoes findings from the SHARE (Sexual Health and Relationships Education) trial in 25 schools in Scotland that highlighted the “potential to influence service use through better knowledge and confidence imparted through school sex education, and by improving the links between services and schools” (16). Family influences, being a school leaver, sexual experience and proximity of service location were associated with service use. Readily available advice, access to contraception and sex educators/family planning advisers trained in youth counselling are also key.

Appropriately trained staff who interact well with young people make it easier for them to discuss otherwise embarrassing or difficult topics (17). A survey of clinics located in youth clubs in Doncaster, United Kingdom (England) among 13–18-year-olds found that young people used them primarily for contraception and also to “chill out”. More than 90% of respondents in this survey found it easy to use the clinics and were happy with their accessibility and the attitude of staff. A young people’s clinic (18–20-year-olds) set within an existing sexual health service in an economically deprived and ethnically diverse area of London showed an increase in male attendance. This was attributed to that fact that the clinic included more male staff and operated on a walk-in basis. Other contributing factors included improved links with other services, such as counselling, that targeted young men and increased condom distribution times (18).

A 2007 report on two drop-in services for young people in the north of England (19) echoes the view that tailoring services to meet the needs of youngsters can help to increase their use. The report referred to two services. The first was a health and support service for people aged 18 and above. It operated in the evenings, was located in an NHS clinic and was staffed by youth workers, a family planning nurse and a school health adviser. The second was a sexual health service for young people situated next to a sixth-form college and staffed by a family planning nurse, receptionist and on-call doctor. Both services had a relatively high rate of return visits. Both services engaged males as well as females. Males often attended with friends, which posed the possibility of confidentiality issues, but these did not arise. The latter service advertised through the college where the clientele tended to be older teenagers and young adults, but the first service, although aimed at those over 18, also attracted very young people seeking advice on sexual health, contraception and relationships.

Findings of a study with pregnant or parenting teenagers in Baltimore, United States concluded that teenagers are more likely to benefit from comprehensive programmes of support/education that provide multiple services (20). Evidence from a cohort study of sexually active teenagers (mean age 16.5 years) in the United States from a range of ethnic backgrounds suggests that support from their mother or male

partner can help teenage women make appropriate choices over sexual behaviour and contraception (21).

Smoking cessation

There is more robust evidence around smoking cessation services than for other aspects of youth health. In 2003, Sowden & Stead conducted a systematic review comparing smoking behaviours of young people involved in preventive interventions (22). This concluded that there was some evidence to suggest that “coordinated multi-component programmes can reduce smoking amongst young people, and do so more effectively than single strategies alone”. The interventions varied geographically (studies were drawn from four countries, including the United Kingdom), in their settings (some were community based and others were provider or school based) and in participant characteristics (for instance, some focused on high-risk teenagers, others on particular ethnic groups). Knowledge of the effects of smoking increased for all, but only those involved in interventions using a social learning theory approach showed a significant difference in smoking behaviour.

Summarizing the evidence from this and other reviews, Krowchuck notes that smoking prevention strategies for adolescents are more effective when they have a design based on the constructs of social influence, are begun in early adolescence, include comprehensive multi-setting interventions delivering age-appropriate messages (in clinics, schools and the community), are culturally sensitive and are periodically repeated to extend efficacy (23). Summarizing the implication for nursing practice, she doubts the wisdom of adding smoking-prevention messages to general health visits, suggesting instead that smoking status be assessed on an individual basis by establishing the existence of any of the known risk factors for susceptibility to smoking (parent or close friend who smokes, receptivity to marketing, truancy or poor school performance).

School-based smoking cessation programmes are widely available in Canada but their poor performance has led some to suggest they be withdrawn, despite their relatively low implementation cost. In a review by Leatherdale & McDonald, pupils who were physically active and those who had previously tried to give up smoking were most likely to engage with school-based cessation programmes (24). While they conclude that there is a need to either modify adult strategies or develop youth-oriented strategies, some formal cessation aids are effective. For example, contrary to previous research findings, young people in the Canadian study were more open to using nicotine replacement therapy than other aids. Further research might help to elucidate the reasons for this and whether they apply to the use of other common aids.

With reference to prevention programmes in the United States and the important role of the community nurse in their delivery, Krainuwat calls for stronger links between community nurses and academics in the development of theory-driven approaches to enhance the benefit to, and from, practice (25).

A recently published study from Iceland outlines a theory-driven programme implemented using evidence-based approaches at community level (26). The main thrust of the intervention was to increase social capital “in order to decrease the likelihood of adolescent substance use” (substances included tobacco, alcohol and cannabis). The approach utilized national data, local dissemination and discussion and local community-based and integrative reflection, in which actions were reviewed and analysed in relation to emerging national data. The nature of Icelandic culture is such that this iterative cycle could be incorporated within one year. Over a 10-year period, substance use among 15–16-year-olds decreased year on year. It was nevertheless impossible to assess the impact of wider cultural variables and replication in different cultural settings may not succeed.

References

1. Veerman J, Yperen T. Degrees of freedom and degrees of certainty: a development model for the establishment of evidence-based youth care. *Evaluation and Program Planning*, 2007, 30:212–221.
2. Perry C. Meeting the sexual health care needs of young people: a model that works? *Child: Care, Health and Development*, 2007, 34:1:98–103.
3. Sherman-Jones A. Young people’s perceptions of and access to health advice. *Nursing Times*, 2003, 99:30:32–35.
4. Linnell S. Seeking young people’s views of primary care. *Nursing Times*, 2002, 98:24:37.
5. Plant B, Mcfeely S, Flynn S. Innovation in general practice: a service for teenagers. *Nursing Standard*, 1999, 13:16:63–69.

6. Milne AC. Health services can be cool: partnership with adolescents in primary care. *Family Practice*, 2000, 17:4:305–308.
7. Walker Z et al. Health promotion for adolescents in primary care: randomised controlled trial. *British Medical Journal*, 2002, 325:524.
8. Malik R, Oandasan I, Yang M. Health promotion, the family physician and youth. Improving the connection. *Family Practice*, 2002, 19:5:523–528.
9. Haller D et al. Toward youth friendly services: a survey of young people in primary care. *Society of General Internal Medicine*, 2007, 22:775–781.
10. Churchill R et al. Do attitudes and beliefs of young teenagers towards general practice influence actual consultation behaviour? *British Journal of General Practice*, 2000, 50:953–957.
11. Richardson-Todd B. Setting up a nurse-run young person's drop-in clinic. *Nursing Standard*, 2003, 17:47:38–41.
12. Van Devanter N et al. A community-based intervention designed to increase preventive health care seeking among adolescents: the gonorrhea community action project. *American Journal of Public Health*, 2005, 95:2:331–337.
13. Green E, Larcombe J, Horbury I. Implementing a teenage health service in primary care. *Nursing Times*, 2005, 101:36–39.
14. Sherman-Jones A. Young people's perceptions of and access to health advice. *Nursing Times*, 2003, 99:30:32–35.
15. Richardson-Todd B. Sexual health services in school: a project in a multi-agency drop-in. *Journal of Family Healthcare*, 2006, 16:1:17–20.
16. Parkes A. Teenagers' use of sexual health services: perceived need, knowledge and ability to access. *Journal of Family Planning and Reproductive Health Care*, 2004, 30:4:217–224.
17. Hayter M. Reaching marginalised young people through sexual health nursing outreach clinics: evaluating service use and the views of service users. *Public Health Nursing*, 2005, 22:4:339–346.
18. Armitage C et al. Are we getting the message across? Trends among young men attending an inner city young people's clinic. *Sexually Transmitted Infection*, 2004, 80:477–479.
19. Perry C. Meeting the sexual health care needs of young people: a model that works? *Child: Care, Health and Development*, 2007, 34:1:98–103.
20. Amin R. Impact of a school-based comprehensive program for pregnant teens on their contraceptive use, future contraceptive intention, and desire for more children. *Journal of Community Health Nursing*, 2004, 21:1:39–47.
21. Harper C. Adolescent clinic visits for contraception: support from mothers, male partners and friends. *Perspectives on Sexual and Reproductive Health*, 2004, 36:1:20–26.
22. Sowden A, Stead L. *Community interventions for preventing smoking in young people (review)*. Oxford, The Cochrane Collaboration, 2003.
23. Krowchuck H. Effectiveness of adolescent smoking prevention strategies. *The American Journal of Maternal/Child Nursing*, 2005, 30:6:371.
24. Leatherdale S, McDonald P. Youth smokers' beliefs about different cessation approaches: are we providing cessation interventions they never intend to use? *Cancer Causes Control*, 2007, 18:7:783–791.
25. Krainuwat K. Smoking initiation prevention among youths: implications of community health nursing practice. *Journal of Community Nursing Health*, 2005, 22:4:195–204.
26. Sigfusdottir I et al. Substance use prevention for adolescents: the Icelandic model. *Health Promotion International*, 2008, 24:1:16–25.

Annex 1

MEETING PROGRAMME

Monday, 21 September 2009

Welcome (Chair: Margaret Burns, NHS Health Scotland)

Opening Ministerial Address (Shona Robison, Member of the Scottish Parliament and Scottish Minister for Public Health and Sport)

Opening Address from WHO. Objectives of the meeting
(Elizabeth Mason, Director, Department of Child and Adolescent Health and Development, WHO headquarters; Enis Barış, Director, Division of Country Health Systems, WHO Regional Office for Europe)

Day 1

Putting in place a supportive legislative and policy environment for youth-friendly health services: what can we learn from each other?

Adolescent health and development: a global and regional overview. Role of health systems (Paul Bloem, WHO headquarters)

The health and socio-cultural issues affecting adolescents in the European Region (Candace Currie, Health Behaviour in School-aged Children (HBSC) International Coordinating Centre)

Strengthening laws and policies through human rights (Marcus Stahlhofer, WHO headquarters)

Exploring the youth perspective on health services (Scottish Youth Theatre)
(Afternoon Chair: Gunta Lazdane, WHO Regional Office for Europe)

Interactive panel discussion:

Specific experiences from each country on supportive legislative and policy environments (Chair: Pierre-Andre Michaud, Switzerland)

- Switzerland
- Tajikistan
- United Kingdom
- European Commission
- European Youth Forum

Summing-up and agree recommendations

Tuesday, 22 September 2009

Day 2

Answering the need for quality: youth-friendly health services

Overview of the day (Chair: Ada Dortch, International Planned Parenthood Federation European Network (IPPF EN))

Strengthening health systems for youth-friendly health services (Valentina Baltag, WHO Regional Office for Europe)

Age-appropriate primary care (Dick Churchill, United Kingdom)

Panel (Chair: Trevor Gibbs, United Kingdom (Scotland))

- United Kingdom (Scotland)
- Ukraine

Panel (cont.)

- The former Yugoslav Republic of Macedonia
- Sweden
- Young people/European Youth Forum

Five tool-based workshops

(Afternoon Chair: Rita Khamzayeva, United Nations Population Fund (UNFPA))

Spotlight session:

Youth-friendly services for all: Are we reaching adolescents most at risk?

(Chair: Nina Ferencic, UNICEF Regional Office for Eastern Europe and Central Asia)

Integration of services for most-at-risk adolescents across health and social services (Ukraine)

What does it take to get services for most-at-risk adolescents youth-friendly? (Neil Hunt, United Kingdom)

Summing-up and agree recommendations

Scottish Government Ministerial Reception hosted by Nicola Sturgeon, Cabinet Secretary for Health and Wellbeing, and Deputy First Minister for Scotland Royal College of Surgeons

Wednesday, 23 September 2009

Day 3

Health care at school: pairing young people with health services

Introduction (Chair: Olivier Duperrex, France)

Organisation of school health services in the WHO European Region: results of the survey (Miriam Levi, Italy)

Evidence-based interventions in school health services
(Sven Bremberg, Sweden)

Panel:

Countries' examples in aligning school health services with needs
(Chair: Vivian Barnekow, WHO Regional Office for Europe)

Panel

- Denmark
- Republic of Moldova
- United Kingdom
- SHE (Schools for Health in Europe)

Panel (cont.) and discussion

Human resources for adolescent health
(Chair: Olivier Duperrex, France)

Professional workforce in adolescent medicine: European countries profiles (Susanne Stronski, European Union for School and University Health and Medicine (EUSUHM))

What are the professional skills required? (Russell Viner, United Kingdom)

Discussion

Meeting recommendations
(Chair: Gunta Lazdane, WHO Regional Office for Europe)

- breakout sessions
- youth voices

Closing remarks

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