

This issue is co-published with NHS Health Scotland and IPPF European Network

YOUNG AND HEALTHY?



Entre Nous

THE EUROPEAN MAGAZINE FOR SEXUAL AND REPRODUCTIVE HEALTH



Entre Nous is published by:

Country Policies and Systems Unit
WHO Regional Office for Europe
Scherfigsvej 8
DK-2100 Copenhagen Ø
Denmark
Tel: (+45) 3917 1602
Fax: (+45) 3917 1818
E-mail: entrenous@euro.who.int
www.euro.who.int/entrenous

Chief editor

Dr. Gunta Lazdane

Editor

Dr. Lisa Avery

Editorial assistant

Dominique Gundelach

Layout

Sputnik Reklame Aps, Denmark.
www.sputnikreklame.dk

Print

Zeuner Grafisk as
www.zeuner.dk

Entre Nous is funded by the United Nations Population Fund (UNFPA), New York, with the assistance of the World Health Organization Regional Office for Europe, Copenhagen, Denmark.
Present distribution figures stand at: 3000 English, 2000 Spanish, 2000 Portuguese, 1000 Bulgarian and 1500 Russian.

Entre Nous is produced in:

Bulgarian by the Ministry of Health in Bulgaria as a part of a UNFPA-funded project;

Portuguese by the General Directorate for Health, Alameda Afonso Henriques 45, P-1056 Lisbon, Portugal;

Russian by the WHO Regional Office for Europe Rigas, Komerfirma S & G;

Spanish by the Instituto de la Mujer, Ministerio de Trabajo y Asuntos Sociales, Almagro 36, ES-28010 Madrid, Spain.

The Portuguese and Spanish issues are distributed directly through UNFPA representatives and WHO regional offices to Portuguese and Spanish speaking countries in Africa and South America.

Material from *Entre Nous* may be freely translated into any national language and reprinted in journals, magazines and newspapers or placed on the web provided due acknowledgement is made to *Entre Nous*, UNFPA and the WHO Regional Office for Europe.

Articles appearing in *Entre Nous* do not necessarily reflect the views of UNFPA or WHO. Please address enquiries to the authors of the signed articles.

For information on WHO-supported activities and WHO documents, please contact Dr. Gunta Lazdane, Country Policies and Systems unit, office T-316 at the address given above.

Please order WHO publications directly from the WHO sales agent in each country or from Marketing and Dissemination, WHO, CH-1211, Geneva 27, Switzerland

ISSN: 1014-8485

Editorial

Rachel Hanretty

3

Investing in Young People: UNFPA's Commitment to Advancing the Rights of Adolescents and Youth in the eastern Europe and central Asia (EECA) Region

By Thea Fierens

4

Accelerating action for adolescent health in the European Region

By Valentina Baltag, Gunta Lazdane, Venkatraman Chandra-Mouli and Bruce Dick

6

A guide for developing national policies on young people's sexual and reproductive health and rights

By Elizabeth Bennour and Irene Donadio

8

Adolescents, the internet and new technologies: a cyber-wonderland?

By Pierre-André Michaud

10

Sexuality education programmes and sexual health services: links for better sexual and reproductive health (SRH)

By Dan Apter

12

Valuing young people: Scotland in context

By Shirley Fraser

14

A personal perspective: sexual bullying

By Kalle Johannes Rose

16

Engaging and involving young people in sexual and reproductive health

By Nuala Healy

18

Croatian school health services and adolescents' reproductive health protection: human and organizational capacity

By Marina Kuzman and Ivana Pavić Šimetin

20

Developing youth friendly primary care services in Bosnia & Herzegovina

By Anne Meynard, Daliborka Pejic, and Dagmar M. Haller

22

Healthy Respect – a national demonstration project on sexual health and young people

By Moray Paterson

24

Walk the talk: supporting the delivery of youth friendly health services in Scotland

By Nuala Healy

25

Quality of care in Estonian youth clinics

By Kai Part, Triin Raudsepp and Helle Karro

26

Reaching most at risk adolescents and youth – Tajikistan's experience

By Nisso Kasymova

28

Resources

By Lisa Avery

30

THE ENTRE NOUS EDITORIAL ADVISORY BOARD

Dr Assia Brandrup-Lukanow

Senior Adviser to the Health Matrix Network
WHO headquarters, Geneva

Mr Bjarne B. Christensen

Secretary General, The Danish Family Planning Association

Ms Vicky Claeys

Regional Director
International Planned Parenthood Federation, European Network, Brussels

Jane Cottingham

Coordinator, Gender, Reproductive Rights, Sexual Health and Adolescence,
WHO headquarters, Geneva

Dr Helle Karro

Professor, Head
Department of Obstetrics and Gynaecology
Medical Faculty
University of Tartu
Estonia

Dr Evert Ketting

Senior Research Fellow
Radboud University Nijmegen
Department of Public Health

Ms Nell Rasmussen

Senior Consultant, Danish Centre for Research on Social Vulnerability

Dr Peer Sieben

UNFPA Representative for Turkey and Country Director for Armenia, Azerbaijan and Georgia

Dr Robert Thomson

Member, Geneva Foundation for Medical Education and Research

EDITORIAL

A young person's perspective on sexual and reproductive health



Rachel Hanretty

Although it fulfils an indulgence in stereotyping, as a young female I do spend a lot of time worrying over and considering my appearance; taking a moment aside to view one's figure in the mirror is not uncommon. However, as a young female, taking a moment to review my own sexual and reproductive health (SRH) and checking that everything is okay is so uncommon that it is often badly misinterpreted by others. This is largely because it is assumed that a young person who goes to a SRH clinic must be going with a negative purpose: an experience of unprotected sex, suspected pregnancy or a possible case of a STI, all of which carry a burden of embarrassment and a scathing, judgemental look from the receptionist at the clinic. Rarely is it assumed that we might actually be being proactive with our SRH, seeking information, advice or access to care that will enable us to live healthy sexual and reproductive lives.

As part of a group of young people who form a Public Partnership Forum, working with NHS Education for Scotland, we have put forward communication issues as one of our top priorities. We have all talked about how one raised eyebrow or unfriendly comment can put young people off from seeking medical help. Why would a young person seek a SRH check up - without an immediate sexual problem - if the health professional is suspecting the worst from a presenting patient and ready to cast judgement? Young people need to be understood in a friendly, approachable manner and where SRH is concerned, it should be the case that going to a clinic should not be shameful. We need to know it will be okay to talk about sex and sexuality.

In order to gravitate towards some mutual understanding between young people and medical professionals the Public Partnership Forum in Scotland is holding our own event - The Sex Factor - for school age pupils to come and learn in one day what they are too afraid of asking adults. We want them to see that beyond the context of a doctor's clinic, services can be developed that are youth friendly, staffed

with health professionals who are friendly and unassuming. Development of quality youth friendly health services, whether they are part of school services, existing clinics or stand-alone facilities, are an essential step towards breaking down the barriers that exist between young people and access to health services and advice. Some might argue that the barrier between young people and older generations has widened with the global spread of networking sites, SMS messaging and wired in earphone and ipod accessories. The Internet and the other media facets that are becoming part of daily life can be utilized across Europe in order to promote good health amongst young people. Old methods aren't working. Posters and fliers are all very well but young people are changing and it's time that health services worldwide moved with the tides.

In Scotland attempts at adopting this informal and friendly approach have proven successful, as is the case with 'The Corner' youth facility in Dundee (see pages 18-19 for more details). Here young people don't need to be ashamed of dropping in because it is a centre that deals with young people's overall welfare, not just SRH. Qualified nurses are available to talk about everything and anything without any stuffy pretentiousness or established protocol and peer-educated volunteers can talk to young people on the same level without a 'should-have-known-better' tone of voice.

Wherever in the world you look, young people hold an increasingly prevalent reputation of being tough, confident and outspoken. Yet, this is also a time for us when we can feel vulnerable - faced with new emotions, development and behaviours. In reality we are often scared of being proactive about our SRH because the positive SRH of young people is often challenged by many societal and cultural taboos. As a young person, this is what I feel ultimately must be addressed and reversed. Governments at all levels need to create and implement policies that recognize our right to positive SRH, including the development of quality youth friendly health services and sexuality education.

As young people we need to be proactive and involved with the decision making process at all levels. We need to be our own advocates so that our voices are heard and our needs are recognized. We need to be involved in open dialogue with all key stakeholders and communicate effectively to promote positive understanding when it comes to the SRH of young people. We need the appropriate life skills and tools to empower us to make informed decisions about all aspects of our health, for the behaviours we learn in our youth can have significant impact on both our present and future health. Perhaps most importantly we need to be seen as partners throughout this entire process.

Meetings such as the "Meeting on youth friendly health policies and services" held in Edinburgh, Scotland, are one such forum that enables young people, SRH experts, policy makers and key stakeholders to come together with the goal of promoting and improving the SRH of young people. I commend the sponsors (NHS Health Scotland, WHO Regional Office for Europe, IPPF EN, European Training for Effective Adolescent Care and Health, UNICEF and UNFPA) and all those involved for taking the steps to address the SRH and needs of adolescents and in doing so working towards ensuring that positive SRH of young people is recognized as a basic human right.

Rachel Hanretty,
young person
Public Partnership Forum
Scotland

INVESTING IN YOUNG PEOPLE:

UNFPA's Commitment to Advancing the Rights of Adolescents and Youth in the eastern Europe and central Asia (EECA) Region

Investing in young people is an investment in the future. Yet more than half of young people throughout the globe live in poverty. Impoverished youth are particularly at risk of gender discrimination, poor schooling, unemployment and poor access to health services. They are also less likely to know of, claim and exercise their rights to reproductive health information and services.

The rights of adolescents to reproductive health information and services has been upheld by numerous international agreements and global forums, including the Convention on the Rights of the Child, the 1994 International Conference on Population and Development and the 1995 Fourth World Conference on Women in Beijing, among others. Yet there remains a huge gap between rights guaranteed in international conventions, and the enforcement of these rights at the national level.

The role of UNFPA

UNFPA seeks to address the rights of adolescent and youth through the framework of poverty reduction. In this manner, UNFPA and its partners propose a holistic and multi-sectoral approach in order to:

- empower adolescents and youth with skills to achieve their dreams, think critically and express themselves freely,
- promote health, by giving them access to sexual and reproductive health information, education commodities and services,
- connect young people to livelihood

- and employment programmes,
- uphold the rights of young people, especially girls and marginalized groups, to grow up healthy and safely to receive a fair share of social investments and,
- encourage young people's leadership and participation in decisions that affect them, including the development plans of their countries.

UNFPA's work in eastern Europe and central Asia Region

In the eastern Europe and central Asia Region, UNFPA advocates, with national governments, for an essential package of social protection interventions for young people. An important component of our work includes creating an environment in which adolescent girls and boys are encouraged to delay childbearing. Delaying childbirth directly saves lives - the life of the mother as well as the child. Babies with adolescent mothers are 1.5 times more likely than those with older mothers to die before their first birthday (1). High rates of early childbearing are directly linked to the practice of early marriage in many countries. It is important to highlight that in many countries in the eastern Europe and central Asia Region, marriage before the age of 18 is permitted by law (2).

During the past fifteen years, UNFPA's eastern Europe and central Asia Region has gained vast experience in working for and with young people to address their growing needs for comprehensive sexual and reproductive health information, education, services and supplies. UNFPA has generated baseline sexual and reproductive health data for national planning and programming, and developed a strategic framework for adolescent sexual and reproductive health in the region. We have developed the technical capacities of healthcare professionals and government officials involved in adolescent and young people's health, and worked with national counterparts to advocate for the integration of sexual and reproductive health education into national curricula. Critical to our successes in the Region



have been the emerging good practices related to youth participation and youth empowerment through Y-Peer, the Youth Peer Education Network, and RHIYSC, the Reproductive Health Initiative for Youth in the South Caucasus. They are successful because these initiatives give young people the power to make their own choices.

Youth participation

Y-PEER is a network of more than 500 non-profit organizations, associations and governmental institutions. Its membership includes thousands of young people, active peer educators, trainers and youth advocates for adolescent and reproductive health. Y-PEER links more than 5000 members from 39 countries in the eastern Europe and central Asia Region, as well as the middle East and north Africa and continues to grow to date. Y-PEER employs a rigorous system of training for peer educators while maintaining an "edutainment" component, using interactive methodologies and a process that is entirely owned by young people. These proven peer education methodologies have been deemed so effective that they are now included in the National Programme on the Prevention of HIV Epidemic and its Social and Economic Consequences in Kyrgyzstan. At a policy meeting in Kyrgyzstan it was noted that "Peer education standards developed by Y-PEER were adopted and introduced to stakeholders and approved by the Government and Civil Society. They serve as a baseline for the standardization of the informal education in the country (3)." The Reproductive Health Initiative for Youth in the South Caucasus funded by the European Commission and UN-



FPA seeks to advance the reproductive health and rights of youth in Armenia, Azerbaijan and Georgia. Young people in these countries are joining efforts, working together, and learning from each other. Activities provided in the past by RHIYSC include the establishment of youth friendly health services, social marketing of condoms and free of charge contraceptives, promotion of parental involvement in the removal of barriers to access for sexual and reproductive health services and promotion of dialogue and experience sharing with partners and stakeholders throughout the Region.

Conclusion

Despite these initiatives, adolescents and youth face many obstacles to sexual and reproductive health information and services that are compounded by their low social status in many cultures as young people. Youth may be reticent to seek reproductive health services due to stigma or mistrust of health care providers. In countries where fee-for-health services are required, youth may not have the resources to pay for required services. Advocates for youth often confront

cultural and traditional taboos related to sexual and reproductive behaviour and limited support for a youth agenda by national governments. The current financial crisis may further limit government's ability to provide needed health care services and infrastructure, at the very moment when demand for health services, due to worsening poverty, will be more acute. Without sustained investment in youth, it will be impossible to meet the Millennium Development Goal (MDG) on poverty reduction. Nor will it be feasible to attain MDG 2 on education, MDG 3 on gender equality, MDG 5 on maternal health, or MDG 6 on HIV prevention. As indicated by a Bulgarian youth advocate, "treating social problems is not only a matter of personal responsibility – it's also part of belonging to a global network with shared responsibility to the young people throughout the world."

Thea Fierens

Regional Director
Eastern Europe and central Asia
Regional Office
UNFPA
fierens@unfpa.org

References

1. UNFPA. *State of World Population 2008. Reaching Common Ground: culture, gender and human rights*. New York: UNFPA, 2008.
2. Rangita de Silva de Alvis. *Eastern Europe and Central Asia Regional Legislative Analysis: A Review of CEDAW Compliance*. New York: UNFPA, 2009
3. Declaration on promotion of SRH and rights, 20 November, 2009, Bishkek, Kyrgyzstan (National Conference on presentation of Peer Education standards and National Forum on presentation of Y-PEER programme for youth NGO's/associations, young leaders, National Commission on Youth Policy, relevant ministries and counterparts, donor community)

ACCELERATING ACTION FOR ADOLESCENT HEALTH IN THE EUROPEAN REGION

Two recent developments are of major importance for shaping the public health agenda in the European Region for years to come: primary health care (PHC) renewal (1) and the Tallinn Charter (2).

The Tallinn Charter outlines directions for health systems development in the WHO European Region if they are to efficiently contribute to health, wealth, and social well-being. The World Health Report 2008 makes the case for global PHC renewal, outlining the four sets of reforms that are needed to meet the expectations of citizens in the modern world: universal coverage, service delivery, public policy and leadership. The two documents share similar values and principles, and describe similar approaches for achieving the improvements that are required. This paper analyses their implications for adolescent health programmes in the Region.

Universal coverage for young people's health

There are many challenges in the European Region that hinder progress towards universal coverage of young people with effective interventions. These include young people's financial vulnerability, cross-border mobility, patterns of exclusion because of a range of factors including sex and age, and the specific needs of marginalized and vulnerable groups. Concerning the financial vulnerability of young people, there are a number of countries where adolescents are not covered by health insurance schemes or specific budgetary allocations. In some countries where youth friendly health services (YFHS) have been developed, the services that are provided rely on time-limited project funds. For certain groups of young people, for example, those whose parents are working abroad and have left their children behind, relatively

small expenditures would be catastrophic. In a number of countries, with the current financial crisis and the diminished employment opportunities for young people, the period is increasing between the end of their insurance status as a child, and the beginning of a career.

Cross-border mobility is increasing in the region. EU mechanisms for cross-border health care try to address the issue of patient mobility, but migrants from outside the EU, many of who are young people, continue to fall through the cracks. For example, in Luxembourg almost 40 % of young people are from other EU Member States, and more than 15% of young people in Spain were non-EU citizens (3).

Boys are generally much less likely to use health services, even if there are specific initiatives to reach adolescents. Age per se may be a factor of exclusion. Traditionally designed health systems were built to serve the needs of ill and disabled people, while adolescents are more in need of preventive oriented services. Sexual and reproductive health service delivery is particularly "age sensitive", with some societies limiting their provision to adolescents.

Marginalized groups of adolescents are frequently not reached by health services even where efforts are under way to make them "adolescent friendly". In the past, many countries of the Region made concerted efforts to bring everyone into the mainstream, with virtually no efforts to provide those few individuals and groups who were not part of the mainstream with health and social services.

However countries are moving forward. The Republic of Moldova recently included YFHS in the list of services covered through mandatory health insurance scheme. There are efforts to respond to the special needs of males, for example by setting aside dedicated clinic times as in Estonia, or to reach marginalized adolescents, such as injecting drug users, as in Tajikistan.

Reforming services to deliver for young people's health

Poor quality of services for young people remains a main challenge to be addressed in service delivery reforms. Low effectiveness, especially in select outdated models of school health services (SHS), is another one. The third challenge is the fact that with the waves of health systems reforms and the trends of a shift towards the needs of an increasingly ageing population, young people's needs tend to be overlooked and neglected.

Health systems that existed in the past were often biased towards detecting health problems and providing curative health services rather than addressing preventive measures. They also tended to be fragmented with specialists focusing on particular organ systems (e.g. in many countries, there were adolescent gynaecologists) rather than on the holistic needs of individuals. As a result of this, health services are often of poor quality both in the way in which they are provided, and in the way in which they meet the expectations of young people. In some countries systems to improve and maintain quality are weak or nonexistent, and there is no commitment to dealing with this. Involving users in the design of health service provision to ensure that it meets their needs is not yet a routine practice in many countries.

The health system reforms provide an opportunity to reorient health service delivery systems to respond to the needs of adolescents. However, in many places, these reforms tend to be blind to the needs of adolescents. For instance, the recent transition to family medicine in many countries of the Region did not take into account that adolescents are as much members of a family as children and the elderly. Consequently, professional capabilities of PHC providers to deal with specific needs of adolescents are extremely limited, and the "age appropriateness" of PHC services is very low. SHS – a particular type of PHC services - have fallen between the cracks in health systems reforms. They continue to abound with non-effective interventions, to focus



Valentina Baltag



Gunta Lazdane



Venkatraman Chandra-Mouli



Bruce Dick

on treatment rather than health promotion and are seen as less prestigious than other PHC professions.

However, progress is being made in many countries in the Region in trying to match services with needs. The United Kingdom is implementing the National Service Framework for Children, Young People and Maternity Services. Several countries – i.e. the Republic of Moldova and Kyrgyzstan – are making efforts in setting nationally agreed quality standards for YFHS so that any facility may be “measured” against them. Denmark, Belgium, United Kingdom and Croatia are just some of the countries that have reoriented SHS from a medical care paradigm to a social care paradigm over the last decades. The Republic of Moldova, Ukraine and Albania also recently embarked on this process.

Public policy reforms

The “health in all policies” call of the renewed PHC acknowledges the importance to address socio-economic determinants of health, as does the Tallinn Charter. In many countries, sectors other than health do not make the needed important contributions, or do so but their activities are not well coordinated.

Per se, “health in all policies” will not address the specific needs of young people unless there is a “young people’s health in all policies” standpoint. The creation of opportunities for girls to study or work as a means of reducing early pregnancies, the decriminalization of needle and syringe exchange programmes, actions to reduce road injuries and violence due to alcohol use, and actions to protect young people against aggressive marketing of the tobacco industry are just some of the examples where the fact that a person is young requires tailored interventions. Multi-sectorial interventions should also address the issues of health care seeking behavior.

Leadership reforms

National level leaders in many countries are not committed to meeting the needs and fulfilling the rights of adolescents.

Often support for actions in health facilities and communities is completely missing at the sub national level. Although evidence about decision making in public health are inconclusive, some from the European context revealed that setting priorities is consistently related to population health status, epidemiological data, burden of disease and, often, scope for prevention (4). Economic argument is increasingly appealing. As adolescents are often a relatively healthy segment of the population, reliance on epidemiological data of disease incidence and prevalence for priority settings becomes less relevant. Rather, the scope for prevention, economic argument, ethical and human rights considerations should be used in obtaining buy-in from leaders of various sectors.

In the framework of the implementation of the European strategy for child and adolescent health and development (2005), 12 countries started the development of their national strategies. While a positive sign of leaders’ increasing awareness and commitment to adolescent health needs, there is a risk that these strategies will not be implemented unless concerted efforts are made to translate the actions proposed into existing work plans and budgets.

Conclusion

The adolescent health programmes, by the nature of their beneficiaries’ needs, are consistent with the PHC renewed approach and the Tallinn charter. They advocate for, and make concrete actions in, ensuring universal coverage, reforming services to make them youth-friendly and make them part of overall health systems reforms. They advocate for public policy reforms along the “young people’s health in all policies” paradigm. Finally, they advocate that leaders from all sectors consider the youth dimension in their policies. In these aspects, adolescent health programmes provide a very useful practical application of the PHC renewed approach and the Tallinn charter – documents that are merely political and directions’ setting – and might

be a litmus test for their implementation. On the other hand, adolescent health programmes should use the opportunity of both the PHC approach and Tallinn charter to accelerate the energy for their implementation.

Valentina Baltag, MD, PhD

Technical Officer
Adolescent SRH including HIV and PHC
Country Policies and Systems
WHO Regional Office for Europe
vba@euro.who.int

Gunta Lazdane, MD, PhD

Regional Advisor,
Country Policies and Systems
WHO Regional Office for Europe
gla@euro.who.int

Venkatraman Chandra-Mouli, MD

Coordinator, Adolescent Health and Development
Department of Child and Adolescent Health and Development
WHO headquarters
chandramouli@who.int

Bruce Dick, MD

Medical Officer, Department of Child and Adolescent Health and Development
WHO headquarters
dickb@who.int

References

1. *The World Health Report 2008. Primary Health Care – Now More than Ever*. Geneva: WHO, 2008. <http://www.who.int/whr/2008/en/>
2. WHO European Ministerial Conference on Health Systems “*Health Systems, Health and Wealth*”, Tallinn, Estonia 25–27 June 2008. Report. Copenhagen: WHO, 2009. http://www.euro.who.int/InformationSources/Publications/Catalogue/20090122_1
3. EU Youth Report. EC, Brussels, 2009
4. Allin S, Mossialos E, McKee M et al. *Making decisions on public health: a review of eight countries*. WHO, 2004 on behalf of the European Observatory on Health Systems and Policies.

A GUIDE FOR DEVELOPING NATIONAL POLICIES ON YOUNG PEOPLE'S SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

IPPF European Network (IPPF EN) has been a lead advocate for young people's sexual health and rights (SRHR) over the years and its Member Associations have piloted initiatives to provide sexuality education, information and services and promote a right based approach towards the SRHR of young people. IPPF EN and like-minded organizations consider that sustainable gains in ensuring young people's SRHR can only be obtained if there is a solid framework of sound and comprehensive policies. Therefore building on evidence, research and our expertise we developed, together with WHO, a set of tools to assist policy and decision makers in providing such a framework.

In 2004-2007 IPPF EN implemented the Sexual Awareness For Europe (SAFE) project in partnership with 26 of its Member Associations in Europe, the WHO Regional Office for Europe, which coordinated the partnership with health ministries, and Lund University (Sweden) which was in charge of the research component. One of the major achievements of SAFE was the Guide for Developing Policies on the Sexual and Reproductive Health and Rights of Young People in Europe. The policy guide is the fruit of the cooperation with representatives of health ministries of the countries participating in the SAFE project and allowed us to work closely with decision makers and implementers. It created a platform of experts that looked in depth at challenges and possible solutions. This collaboration also permitted a constructive dialogue with governments, the creation of trust between different actors, wider ownership and political momentum. Furthermore a key element for the development of the guide was youth participation and the involvement of the young people from IPPF EN's youth network (YSAFE). The guide complements the WHO European Strategy for Child and Adolescent Health and Development. Other tools include a policy brief (1) and four fact sheets on good practice in addressing young people's SRHR.

The Policy Guide takes a positive and

comprehensive, rights-based approach to young people's SRHR. It recognizes that while there are basic underlying principles that should be a common thread for policies, policy implementation will vary depending on national legislation and political setting, service structures and other national considerations. Box 1 outlines cross-cutting elements of policy making in this field.

The SAFE partners selected five policy areas considered to be key in ensuring the SRHR of young people (see Box 2). A separate chapter for each of these areas provides a detailed discussion of the issues and principles at stake, followed by a checklist for action by national and/or regional governments/agencies.

Stakeholder involvement: an essential element in policy development and implementation

IPPF EN firmly believes that in order to introduce policies to promote and ensure the SRHR of young people, it is essential to have multi-stakeholder and multi-agency involvement and support. Greater information and broader experiences and support make it easier to develop and implement realistic policies and plans, allow new initiatives to be embedded into existing legitimate local institutions, enable less opposition and greater political leadership, and develop local capacities.

Stakeholder involvement can be classified into three types: i) instructive, ii) consultative and iii) cooperative. Instructive involvement is where government makes the decisions but mechanisms exist for information exchange. Consultative involvement is where government is the decision-maker but stakeholders have a degree of influence over the process and outcomes. Cooperative involvement is where primary and key stakeholders act as partners with government in the decision-making processes.

In the field of young people's SRHR key stakeholder involvement is essential because of the controversy attached to young people's SRHR and because of the intended social change. Furthermore, cooperative involvement, negotiation,

trust and ownership building is essential to bring about the 'change' of political attitudes and social norms necessary to achieve better SRHR policies for young people. Moreover, it is crucial that in the policy making process the capacities and aspirations of the stakeholders themselves are valued and respected.

In determining the stakeholders it is important to consider who will be affected by the desired change and how, and what needs to be done to ensure that an enabling environment is created to bring about change. In the case at hand, the primary stakeholders were the young people themselves, and the key stakeholders were the networks supporting them: families, teachers/schools, medical professionals, judges, social workers, police, media, opinion leaders and role models for young people, local authorities, parliamentarians, religious groups, specialized agencies of service providers, advocates and researchers. In our field in particular it is of crucial importance that all the groups that might be affected in some way, that feel they have a legitimate stake in the issue or will have a role in the process, are properly involved and given a voice, space and some power to contribute/decide.

An example of best practice is Scotland's experience in developing and introducing a national sexual health strategy.

Taking up the challenge

IPPF EN and its partners are currently preparing to embark upon SAFE II. One of the main work streams under this new 3-year project will include focused advocacy in several European countries for government adoption of comprehensive policies on young people's SRHR using the SAFE policy guide as a tool. These efforts will be undertaken in close collaboration with young people and key stakeholders from among the groups mentioned above, and will also involve representatives of relevant ministries and government agencies (e.g. health, education). A compendium on the state of policies on young people's SRHR in 24 EU Member States will also be developed



Elizabeth Bennour



Irene Donadio

WHAT MAKES A SUCCESSFUL YOUTH-FRIENDLY SRHR POLICY?

A youth-friendly SRHR policy respects diverse values held by a wide range of groups, provides age-appropriate information that addresses the realities of young people's lives and takes the perspective that sexuality is a positive force and not something to fear. It should also take into account and integrate a number of essential cross-cutting issues and principles related to young people's SRHR, including:

• Involvement of young people

The participation of young people in policy development ensures that policies and programmes meet their real needs. Policymakers are urged to call on youth councils or to create youth advisory panels on SRHR to participate in the policy process.

• A gender focus

Boys and girls have a variety of different needs and risks. Women, especially young women, are biologically more vulnerable than men to diseases related to the reproductive system. Both sexes are at risk of sexual abuse and exploitation. Young gay men and lesbians are particularly vulnerable to discrimination.

• Recognition of diversity and vulnerability

Young people come from a broad range of social, economic, ethnic and cultural backgrounds and have different sexual identities. Flexible and creative approaches are needed to reach marginalized young people or those with special needs, and to accommodate the different settings in which they live.

• Protection policies for young people

Young people have the right to physical, psychological and social protection, particularly those with special needs, such as sexually abused and trafficked young people, teenage mothers, young people with disabilities, young people with HIV, and victims of female genital mutilation. The legal systems should provide an adequate framework for young people's SRHR that is protective and supportive.

• Multi-sector support

The SRHR of young people is not purely a health issue, nor only the responsibility of health workers. Government ministries should develop a national strategy to ensure multi-sectoral collaboration, including publicly-funded structures and primary and secondary stakeholders including youth organizations, non-governmental organizations (NGOs) and community-based groups in both the national strategy development and its implementation.

• Effective monitoring and evaluation

There is a lack of data on the SRHR of young people in Europe, particularly comparative data. To have a better understanding and be more effective, all countries should improve comparative data collection. The Health Behaviour in School-aged Children survey is one important tool that does this. NGOs and young people have a key role to play in conducting formative research, interpreting results, developing and implementing programmes, and being engaged in the monitoring and evaluation of policies and programmes.

Box 1

and disseminated. The compendium will be designed around the checklist for action in each of the five key policy areas outlined in the policy guide.

Elizabeth Bennour

Director of Programme & Advocacy,
Regional office, IPPF EN, Brussels
ebennour@ippfen.org

Irene Donadio

Advocacy Officer
Regional Office, IPPF EN
Brussels
idoadio@ippfen.org

References

1. *Developing Policies on the Sexual and Reproductive Health and Rights of Young People in Europe* <http://www.ippfen.org/en/Resources/Our+publications/SAFE+Policy+brief.htm>
2. WHO. *Safe abortion: technical and policy guidance for health systems*, Geneva: WHO, 2003.

Box 2

Five Key Policy Areas	
Policy area 1: Information, education and communication	High-quality information and comprehensive sexuality education equips young people with the knowledge, skills and attitudes needed for informed choices now and in the future.
Policy area 2: Health services	Youth-friendly services are those that attract young people, respond to their needs, and retain young clients for continuing care, based on an understanding of and respect for the realities of their diverse sexual and reproductive lives.
Policy area 3: Access to contraception	Access to contraceptives is an integral element of any strategy for reducing rates of unwanted pregnancies and is a demand of the youth movement. Promoting regular and effective use of contraception cannot be addressed simply by making contraception available. Programmes must also include information and education on a wide range of issues, such as social values, gender equality, personal relationships, and drug and alcohol use and aim to create an empowering environment for young people. Young people often have limited financial means and, therefore, difficulty purchasing contraceptives. This should be addressed in national strategies on SRHR.
Policy area 4: STIs and HIV/AIDS	Reported rates of STIs are increasing across Europe with young people at increased risk. The importance of STIs/HIV prevention in youth needs to be addressed. Positive prevention should increase the self-esteem and confidence of HIV positive individuals to protect their health and build healthy and happy relationships and families.
Policy area 5: Unwanted pregnancy and safe abortion	At a time of life when fertility is high and young people have limited experience using contraceptives, there is a greater risk of unintended or unwanted pregnancies. Sexuality education, the availability of contraceptives and youth-friendly services should all be components of a comprehensive approach to SRHR which should also lead to reducing unwanted pregnancies and abortion. Nevertheless, it is not possible to completely eliminate unwanted pregnancy because of the multiple causes and factors involved with it. When performed by a trained healthcare provider with the proper equipment and under safe conditions, abortion is one of the safest medical procedures (2).

ADOLESCENTS, THE INTERNET AND NEW TECHNOLOGIES : A CYBER-WONDERLAND?

The way in which the Internet and new technologies will affect our existence in the future remains to be recognized, but already there are lessons that can be learned from the last ten to fifteen years, particularly where adolescents and health are concerned.

Adolescents are great users of tools such as mobile phones, electronic diaries, i-phones and personal computers: on one hand, they familiarize themselves with any new technology much quicker and more easily than adults do; on the other hand, all these devices are so appealing to young people, that they represent a highly appreciated – if not naively exploited – target for the sale of such tools. It should also be mentioned that, in low income countries, compared to traditional paper documents and land lines, the wireless connection as well as access to the web allows quick and easy access to information; it follows that this huge technological leap will help these countries to close the gap they faced in the past. Indeed, while nowadays the vast majority of adolescents, in developed countries, are connected in one way or another, the percentage of young people in low or middle-income countries having such access is increasing rapidly.

Often, parents, educators, health professionals or politicians tend to demonize new technologies arguing that they may contribute to the spread of violence, pornography, or make adolescents dependent (1). While this may be the case for a minority of more vulnerable individuals, most adolescent girls and boys cope fairly well with all these new tools. This brief review will discuss these new technologies potential impact on the learning and socialization processes of adolescents, as well as, how they can affect their health.

Promoting education and learning

In the field of education and learning, the Internet constitutes a unique source of information for all adolescents. It stimulates their curiosity and assists them in the preparation of documents. The condition for proper use requires adequate support and assistance from adults and teachers. Along the same line, the Internet is an appealing socialization tool that allows for exchanges not only with close mates and friends, but also with correspondents from all over the world. In this respect, the existing chats and forums allow for

interactions which can be very stimulating and builds on the natural interest and needs of adolescents' to engage themselves in the exploration of their environment and of the world, as well as, the construction of ideals (2).

For handicapped young people and those suffering from chronic conditions, the cell phone and the computer constitute a mean to – at least partly – overcome the isolation linked with their impairments. There are sites which allow for exchanges between youngsters suffering from specific diseases or who are hospitalized. Also, for older adolescents, the web is a potential source of information on their disease, on new treatment, or on the normal course of their illness. It thus may empower them, providing a sense of control over their condition. Finally, more and more health professionals use the cell phone as a reminder tool to increase therapeutic adherence, to remind youngsters of their appointment, or to communicate the results of lab tests (3).

Information, prevention and advice

Several informative websites have been developed, which aim to provide young people with health information, preventive messages or specific advice. They currently exist in different languages such as English, French, Spanish or Russian. Many of the quality websites are run, or at least supervised, by health professionals. A non-governmental agency located in Geneva, Switzerland, named Health on the Net can validate the quality of such websites. Some sites offer the possibility for users to ask their own questions and receive specific answers. It is possible to access to the whole range of questions asked and answers provided, and thus provide an illustration of the wide range of preoccupations which teenagers have at various periods of their life, including growth and puberty, sexual life, nutrition, mental health and depression, substance use, etc. Furthermore, these sites constitute a useful teaching device for doctors in-training, who can learn more on how young people express their questions or



Pierre-Andre Michaud

opinions regarding their health, and how to address these issues in a simple, accessible but accurate language (4).

Potential negative consequences

There are of course also several pitfalls linked with the use of new technologies. One of the main concerns is the lack of control of any formal agency on the quality and the content of Internet websites (1). This is why it is important for parents to monitor, especially among children and younger adolescents, the use of the computer and of the cell phone. Indeed, for some of these young users, it is difficult to differentiate between the virtual and the real world. In other words, adults have a responsibility not only to survey what the young people see, but also to discuss openly with them the meaning of the information, images and proposals they have access to.

Several specific potential threats to the health and well-being of adolescents should also be mentioned: cyber-bullying has recently been recognized as a subtle, but destroying, way for adolescents to harass or repeatedly menace their peers, with clear harmful consequences for the victims in terms of mental health and self-image (5). Pornography and violent scenes can be quite disturbing for young unprepared adolescents, especially if this access is not supervised by adults and thus not accompanied by a “debriefing” discussion. The transfer between adolescents of erotic images, obscenities or verbal attacks of individuals through SMS is a recent phenomenon which exemplifies the lack of capacity of young people to discriminate between the private and public arenas, as well as, their ignorance of the legal regulations in this domain. The exchange of information, addresses, or of invitations, as well as, the organization of encounters through the internet with persons who are unknown to the adolescent user can potentially lead to dramatic events, such as extreme violence or sexual abuse. Finally, there are certain websites that encourage the adoption of harmful behaviors such as eating

disorders, or even suicidal conducts (6). As a result in some countries – notably in Scandinavia - schools have already implemented formal curricula that attempt to educate young people in the appropriate use of all these technologies, but this is far from being the rule.

Another area of great concern is the issue of the amount of time spent on the Internet by adolescents. It is virtually impossible to define the boundary between adequate and excessive use of new technologies as it is not only a question of numbers of hours, but also type of use, as well as reasons for using the computer. Young persons who utilize the computer to chat with others, to discover new fields of interest, or to construct new spaces are probably much less destined to become dependent than those who use the computer for the thrill brought by the game and the satisfaction to win. In this regard, one of the biggest threats to health is linked with the existence of so-called MMORPG (Massively Multiplayer Online Role Playing Game) in which users become dependent on the extent of their time involvement to gain credits and esteem from the other players, spending more and more time on their computer.

Conclusion

As can be understood from this discussion, the Internet, the cell-phone and other new devices represent two sides of the coin. They signify access to a huge amount of health information and a fantastic means for positive exchanges and connectedness, but at the same time represent a threat to some adolescents' health and development. The objective of our society thus is to set-up, in as many settings as possible, an appropriate sensitization of adults and of adolescents on the limits, the pitfalls and the potential harmful effect of the inappropriate use of the web and of cellular phones. Health professionals, in particular, are well positioned to increase the awareness of the all concerned adults on the challenges posed by new technologies.

Pierre-André Michaud, MD
Professor, Multidisciplinary Unit for Adolescent Health
CHUV/University Hospital Lausanne
Perre-andre.michaud@chuv.ch

References

1. David-Ferdon C, Hertz MF. Electronic media, violence, and adolescents: an emerging public health problem. *J Adolesc Health* 2007; 41:S1-5.
2. Williams AL, Merten MJ. A review of online social networking profiles by adolescents: implications for future research and intervention. *Adolescence* 2008;43: 253-74.
3. Marsch LA, Bickel WK, Grabinski MJ. Application of interactive, computer technology to adolescent substance abuse prevention and treatment. *Adolesc Med State Art Rev* 2007;18:342-56, xii.
4. Gray NJ. Adolescents, the Internet, and health literacy. *Adolesc Med State Art Rev* 2007;18:370-82, xiii.
5. Smith PK, Mahdavi J, Carvalho M, Fisher S, Russell S, Tippett N. Cyberbullying: its nature and impact in secondary school pupils. *J Child Psychol Psychiatry* 2008;49:376-85
6. Norris ML, Boydell KM, Pinhas L, Katzman DK. Ana and the Internet: a review of pro-anorexia websites. *Int J Eat Disord* 2006;39:443-7.

Examples of health websites for young people:

<http://www.ciao.ch/>

<http://www.goaskalice.columbia.edu/>

<http://www.teenhealthfx.com/answers/health/index.html>

Examples of training websites for health professionals

<http://www.euteach.com>

http://ec.europa.eu/education/programmes/newprog/index_en.html

www.usc.edu/adolhealth

Foundation Health on the Net :

<http://www.hon.ch/>

SEXUALITY EDUCATION PROGRAMMES AND SEXUAL HEALTH SERVICES:

links for better sexual and reproductive health (SRH)

SRH for adolescents is based on three fundamental components: 1) recognizing sexual rights, 2) sexuality education and counselling and 3) confidential high quality services. These components all need to be considered together. The closer sexuality education programmes and sexual health services (SHS) work together, the better the results.

In Nordic countries the SRH of young people is relatively good when compared internationally, with relatively low numbers of unintended pregnancies, abortions and sexually transmitted infections (STIs). This situation has of course evolved over time. Sixty years ago the situation in Finland was quite different: illegal abortions and STI's were common, sex education was non-existent and attitudes towards sexuality and contraception were negative. In general, the overall development in society - gender equality, equal education opportunities for boys and girls, development of the health care system and positive attitude changes of the state and church have all made it possible to reach the present situation through extended provision of sufficient and reliable sexuality education, confidential and high-quality services and wide selection of contraceptive methods (1).

Many of the problems of adolescence are related to the unwillingness of our culture to adapt to the structurally changing position of adolescents in society. In modern society, young people develop physically and emotionally at a rather young age, yet it is several years later before they are ready to start a family. For example, the mean age at first intercourse for females in Finland is close to 17 years of age, mean age at first marriage 27, and at first delivery 28 year of age. This growing gap between physical maturity on the one hand, and "social maturity" on the other causes many of the problems of adolescent sexuality.

SRH services for adolescents can be provided in various settings, as long as certain basic principles are observed. The services should have a youth-friendly

atmosphere, where young people can feel welcome and comfortable. Unquestionable confidentiality is very important. The providers must not moralize and judge the adolescents, but have a positive attitude in changing risk behaviour and treat adolescents with respect indicating that young people are important. In this way self-esteem is strengthened, and adolescents learn to respect and take care of themselves and others.

Health care in Finland, as in many other countries, is organized into different levels: primary, secondary and tertiary health care. Primary health care (PHC) provides the basis of the health care organization and school health care (SHC) is an essential part of it. Finland has not set up a network of youth clinics; specific clinics for adolescents exist only in some of the biggest towns. On the other hand, SHC is an essential part of PHC. It is provided in all municipalities and covers health care free of charge for the pupils in primary and secondary education. Thus, clientele of SHC consists of almost the entire population from ages 7 to 16. Its aim is to promote healthy growth and development of the child and adolescent. Health education and counseling are key elements of SHC. Recognition of possible problems and health risks, screening and advice for healthy ways of living belong to preventive health care. SHC also embraces a holistic approach, collaborating with parents, teachers, psychologists, physiotherapists and nutritionists.

The other basis for good SRH is sexuality education, which needs to be continuing, well planned, and adapted to the developmental stage of the child. Sexuality education became obligatory in schools in Finland in 1970 and the quality and content slowly developed. In most schools, there was a close connection between sexuality education and SHC supporting each other and promoting the same messages. Together, in combination, these improved SRH, increased contraceptive use, and contributed to the decline in adolescent abortions and deliveries from 1975-1995 shown in Figure 1.

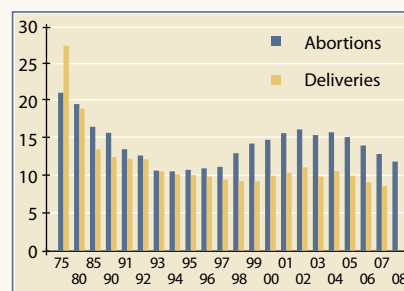
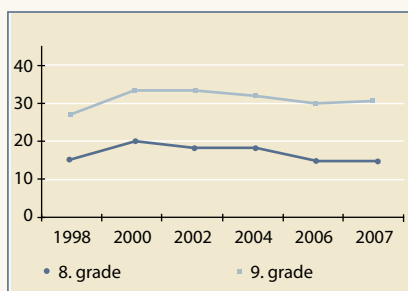


Figure 1
Abortions and deliveries per 1000 girls 15-19 year old in Finland 1975 to 2008 (2).

Changes in education and health care during previous economic depression

During the early-mid 1990's, due to the economic recession, resources for health and social services were cut in Finland, and many municipalities "saved" by reducing the number of people employed in health care. Cuts were carried out in all health and social care, but preventive health care, such as SHC, was particularly hard hit. In addition, in an attempt to cut costs, education also shifted towards a more decentralized system. As a result, from 1994, sexuality education became an optional subject, with each school deciding by itself if and how to teach it. This led to a marked deterioration in both the quality and quantity of sexuality education provided in schools (3). Assumingly, the simultaneous reductions in health and education led to the 50% increase seen in adolescent abortions in the latter part of 1990's (Figure 1). At the same time, until 2002, the number of detected Chlamydia infections increased markedly. Annual school health surveys by Stakes (National Institute for Health and Welfare) started in the late 1990's (every even year in the eastern part of Finland and every odd year in the western part of Finland) and covered the whole country. The large questionnaire included questions about sexual behaviour and contraceptive use. As seen in Fig 2A, in the late 1990's the percentage of girls starting to have intercourse at an early age (age 14 and 15) increased, while at the same time until 2002, the percentage who used no contraception increased as well (Fig 2B).

**Figure 2A**

% of girls who have had intercourse (A), and % of girls who did not use any contraception at last intercourse (B), grade 8 (mean age 14,8) and 9 (mean age 15,8), Finland 1998-2007 (4).

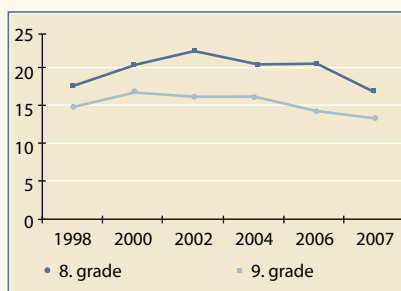
Recent developments with sexuality education

Slowly, based on the above information, the education system was changed and the National Board of Education actually developed guidelines for sexuality education that were quite good. These were based on a holistic approach to sexuality. A new subject called "Health" was included. Teaching started in most schools in 2003-2004, and has been obligatory in all primary and secondary schools since 2006. Teachers are trained, and one teacher per school is responsible for coordination of the topic. In grades 7-9, sexuality education is provided for at least a mean number of 20 hours. A detailed study has been done by Väestöliitto, Family Federation of Finland, on the content of sexuality education provided and the SRH knowledge of 8 grade pupils. Particularly for boys, school sexuality education influenced knowledge (3).

Basic prerequisites for good SHC

In Finland, the basic prerequisites for good SHC have been discussed and defined. These are listed below.

1. SHC should have a sufficient amount of staff. A full-time school nurse should be responsible for the care of not more than 600 pupils. If she works in more than one school, the amount of pupils should be less. A school doctor should have at least one working day per week per 1000 pupils. In addition to clinical work, the staff should have time to plan SHC activities, to supervise the working

**Figure 2B**

conditions at school, to teach health education of the pupils, to network and to access continuous education of their own. At school a school psychologist and a social worker should also be available.

2. The workrooms reserved for SHC should be appropriate.
3. In each health district there should be an identified doctor whose specific responsibility is SHC. S/he is responsible for the overall planning of SHC and ensures that SHC has sufficient possibilities to operate and that new workers will be adequately trained to participate in SHC. In larger municipalities a school nurse is also needed to co-ordinate SHC. Special responsibilities are taken into account in the salaries of the staff involved.
4. The staff should use an equivalent of at least 10 working days for continuous education regarding SHC.

SHC is a part of the school community. Its aim is to ensure that the school provides an environment for its pupils that promote their physical and emotional health and well-being. SHC actively participates in health education at school. The school nurse follows each pupil's development and health by yearly check-ups. An extended check-up by the school doctor and the school nurse is performed when the pupil starts school, and at grade 5 and 8 when s/he is aged 11 to 12 years, and 14 to 15 years according to an Act of Parliament in May 2009. Counselling about sexual health including pregnancy prevention is particularly mentioned. The school nurse can also start hormonal

contraception.

Conclusion

Since 2004, with the improvement in quality of sexuality education, there has been a continued improvement in the SRH of adolescents in Finland. Both the percentage of girls starting to have intercourse at an early age, during grade 8 or 9 (aged 14-15) (Figure 2A) and the percentage that used no contraception has decreased (Figure 2B). There has also been a marked decrease in adolescent abortions from 15.7 per 1000 in 2004 to 12.3 per 1000 in 2008. During the same time, a smaller decline also took place in delivery rates (Figure 1). There also seems to be a cohort effect, with a carry over of a higher abortion rate to the older age groups with time.

In conclusion, when adolescent sexuality is not condemned but sexuality education and SRH services are provided instead, it is possible to profoundly improve adolescent SRH with comparatively small costs. Each year new groups of young people mature, requiring new efforts. Education, counselling and services are all needed. If the resources are not provided or alternatively, reduced significantly, as recently occurred in Finland, negative effects are soon evident.

Dan Apter, MD

Director
The Sexual Health Clinic,
Väestöliitto (Family Federation of
Finland),
dan.apter@vaestoliitto.fi

References

1. Lottes I, Kontula O. *New Views on Sexual Health: The case of Finland*. Väestöliitto D37, Helsinki 2000.
2. <http://www.stakes.fi/FI/Tilastot/Aiheittain/Lisaantyminen/raskaudenkeskeytykset/index.htm>
3. Kontula O, Meriläinen H. *Koulun seksuaalikasvatus 2000-luvun Suomessa*. Väestöliitto Väestöntutkimuslaitos Katsauksia E 26/2007
4. <http://info.stakes.fi/kouluterveyskysely/EN/index.htm>

VALUING YOUNG PEOPLE: SCOTLAND IN CONTEXT

Scotland is one of the four countries that make up the United Kingdom. It has a population of 5.16 million, of which 18% are under the age of 18. The devolved Government for Scotland is responsible for most of the issues of day-to-day concern to the people of Scotland, including health, education, justice, rural affairs, and transport. There are 14 health authorities and 32 local government areas. Key public health concerns include coronary heart disease, alcohol/drug misuse, mental ill health including suicide, smoking and sexual ill health, as well as, health inequalities.

Young people

There is a cross government commitment to improving the lives of young people in Scotland with a focus on:

- ensuring that all young people have the support they need to achieve their potential;
- positive opportunities for and positive engagement with young people; and
- early intervention to nurture potential and offer support at an earlier stage in a young person's life.

In 2009, the Scottish Government with a range of National Health Services (NHS) and non NHS partners launched "Valuing Young People: Principles and Connections to support young people achieve their potential", which provides a common reference tool for any professional delivering services to young people. Youth friendly health services is one of the nine delivery 'pillars' identified to help young people achieve the 4 capacities (successful learners, confident individuals, effective contributors and responsible citizens) outlined in the National Delivery Plan (see figure 1).

The Scottish Government supports the provisions of the United Nations Convention on the Rights of the Child and Scotland's Commissioner for Children and Young People has developed resources designed for young people to help them know their rights (available at <http://www.sccyp.org.uk/webpages/cypr.php>). Scotland also has its own Youth Parliament with subject committees, including health and education. The Scottish Youth Parliament, designed and

led by young people, is committed to ensuring that the voice of young people is listened to by all decision makers.

Sexual health policy in focus

Respect and Responsibility: Scotland's Strategy and Action for Improving Sexual Health

The Scottish Government's commitment to address Scotland's poor record on unintended pregnancies and STI's, including HIV/AIDS, was first flagged in "Our National Health: A Plan for Action, A Plan for Change (2001)" with a commitment to developing a national strategy made in "Improving Health in Scotland: the Challenge (2003)". The issues to be addressed included:

- a general decline in the overall pregnancy rate in adolescent's under 16 but still the highest in western society;
- significant links with economic deprivation and sexual ill health;
- use of condoms primarily for prevention of pregnancies rather than for protection against STI's;
- increasing diagnoses of STI's, especially Chlamydia and HIV; and
- rising rates of induced abortions and repeat induced abortions in women over 25.

In the summer of 2003, the Minister for Health and Community Care commissioned the former Public Health Institute of Scotland to lead the development of a draft strategy. Following an analysis of sexual health (SH) strategies internationally and in other UK countries and a two-year period of policy development and engagement with key partners, "Respect & Responsibility", Scotland's first SH and relationships strategy, was published in January 2005. This strategy provided an evidence-based national action plan for improving SH and relationships across all ages. Underpinned by the WHO definition of SH, it promotes the principles of respect for self, respect for others and strong relationships. In recognizing the diversity of lifestyles in the population of Scotland, the action plan seeks to improve access to information and services whilst enabling flexibility for local services to respond to local needs.

The overarching and interdependent aims of the action plan are:

- providing better services by improving the quality, range, consistency, accessibility and cohesion of SH services that are safe, local and appropriate;
- promoting respect and responsibility by supporting everyone in Scotland to acquire and maintain the knowledge, skills and values necessary for good SH and well-being; and
- preventing STI's and unintended pregnancy by positively influencing the cultural and social factors that impact on SH.

To achieve these aims, actions are directed to key national and local health care and local government statutory agencies as well as to Scottish Government. Central funding of £5 million per year was provided and strong visible leadership and direction provided through:

- the Minister for Health and Community Care chairing a national SH advisory committee;
- lead clinicians in SH appointed in each local health agency to guide local implementation;
- learning from the robustly evaluated national health demonstration project on young people's SH, Healthy Respect, being shared throughout Scotland;
- clear and transparent reporting mechanisms with progress and funding published; and
- clear targets identified for reducing unintended pregnancies (reducing pregnancy rate in 13-15 year olds from 8.5 per 1000 in 1995 to 6.8 per 1000 by 2010).

During the period 2005-2008, progress was particularly made in:

- more integrated SRH services;
- increased focus on opportunistic testing and treatment of key STI's among young people, including antenatal HIV testing;
- the promotion of drop in services for young people and service standards;
- the development of quality standards for SH services;
- improved national data collection through monitoring of key clinical in-



Shirley Fraser

dicators and development of national electronic clinical data system across family planning and genito-urinary medicine services;

- co-ordinated efforts to promote positive sex and relationships education within schools and other educational settings with a review of activity in secondary schools; and
- sharing learning and experiences around evidence and practice through a specific Wellbeing in Sexual Health network. (www.healthscotland.com/wish)

Review of progress and next steps

In 2007, NHS Health Scotland, in joint collaboration with the Scottish Government, commissioned an evaluation of “Respect and Responsibility” with a view to assessing whether the actions were in the right direction or if a renewed focus was required. This review highlighted the need to continue support for SH service provision but also emphasized the need to influence the sexual wellbeing culture of Scotland. It also indicated a need for a smaller national committee with a continued focus on sexual wellbeing but with the inclusion of HIV issues. The Minister for Public Health and Sport has demonstrated continued commitment for this topic by chairing this group.

Further actions are identified in “Respect and Responsibility: delivering improvements in sexual health outcomes 2008-2011” with the following specific long term outcomes:

- reduced levels of regret and coercion;
- reduced levels of unintended pregnancy, particularly in those under 16 but also to see a reduction in the number of repeat induced abortions in all ages;
- reduced levels of STI’s, recognizing that there will first of all have to be an increase due to increased testing;
- increased access to SH information and uptake of services;
- reduced levels of HIV transmission, particularly amongst men having sex with men; and
- reduced levels of undiagnosed HIV, particularly amongst men having sex with men and African populations.

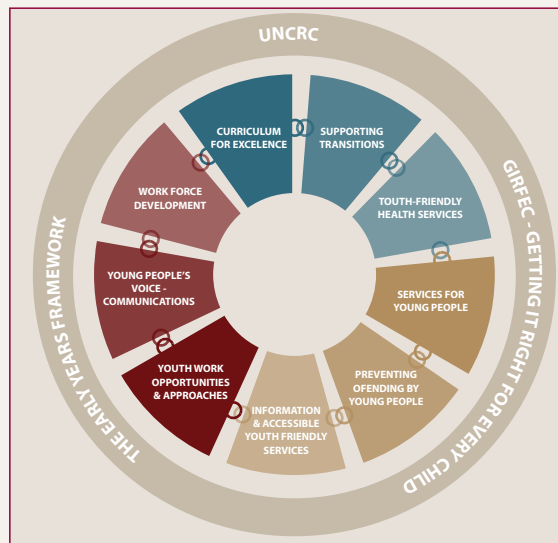


Figure 1 Valuing young people – Delivery pillars (Scottish Government 2009)

campaign aimed at the general population aged 20-40 which will provide a backdrop to other activities (led by Scottish Government) – release in August 2009;

- specific social marketing activities for professionals and target audiences on:
 - The promotion of longer-lasting reversible contraception (IUS, IUD

and implants) as a means of reducing unintended pregnancies and repeat terminations in all ages – released in July 2009;
- The testing of approaches around HIV prevention with men who have sex with men (and then with African communities) – release in early 2010.

All of this work is being informed by attitudinal research with the target audiences. In addition, the Scottish Government has made a commitment to provide better access to independent SH information including:

- a dedicated public website which aims to provide information on sexual ill health, direct users to services and other support mechanisms – www.sexualhealthscotland.co.uk;
- a series of standardized leaflets on STI’s and vaginal health (produced by NHS Health Scotland and available in nine core languages) to ensure consistency across Scotland – will become part of downloads from the electronic data collection system and text replicated on website; and
- a Scottish identity for SH services – Sexual Health Scotland – and an expectation that local areas will adopt this.

NHS Boards and their stakeholder partners are working towards achieving these outcomes in their own areas and are supported at national level through the provision of training, resources and quality standards. Annual visits by the Scottish Government are undertaken to ensure progress is maintained on achieving the greatest impact on poor SH outcomes but also to identify where further national support may be required.

As indicated, there is a greater focus on HIV issues, particular in relation to the prevention of HIV transmission and the co-ordinated and consistent delivery of high quality care and treatment for people with HIV in all parts of Scotland. The Scottish Government is currently engaging with key stakeholders on its draft HIV Action Plan and the central aims of this plan are to:

- prevent HIV infection where possible,
- detect infection early,
- provide high quality treatment and ongoing support to those who need it.

Improving the sexual health and wellbeing culture of Scotland

Whilst “Respect and Responsibility” aimed to promote positive sexual wellbeing, it was recognized that the initial implementation has focused primarily on actions to reduce sexual ill health. In the next three years, there will be specific actions focused on the culture around relationships and SH, such as:

- a broad-based social marketing

and implants) as a means of reducing unintended pregnancies and repeat terminations in all ages – released in July 2009;

- a dedicated public website which aims to provide information on sexual ill health, direct users to services and other support mechanisms – www.sexualhealthscotland.co.uk;
- a series of standardized leaflets on STI’s and vaginal health (produced by NHS Health Scotland and available in nine core languages) to ensure consistency across Scotland – will become part of downloads from the electronic data collection system and text replicated on website; and
- a Scottish identity for SH services – Sexual Health Scotland – and an expectation that local areas will adopt this.

Shirley Fraser
Health Improvement Programme Manager
NHS Health Scotland
Shirley.fraser@health.scot.nhs.uk

A PERSONAL PERSPECTIVE: SEXUAL BULLYING

– a downside of liberalism and individualism

In many northern and western European countries during the last years children have been increasingly pushed to identify themselves as select sexes with select gender roles. Society and parents often put pressure on children to assume the primary ideas of individualism. As a result the defined childhood period of unity, where sex and gender are not the primary focus, but social interaction of the group is considered top priority, has been lowered.

Previously the time period of childhood went from birth to the end of the teenage years. Now children are already forced to align themselves with a specific sex and gender, often as early as the age of 5-6, largely as a result of society's pressure for uniqueness and individualism, the goal being to automatically recognize and respect each human being as unique as soon as the sign of self-developed action appears. The effect of putting such decisions upon a child's shoulders at an age when the child is not adequately developed at the demanded psychological stage, forces the child to do what s/he cannot. Therefore the outcome of such an evolution tends to be that a child seeks the answer to fulfil the expectations of society by copying those who have given the child answers to all other questions, the grown ups. Due to this outside pressure children take in words, actions and behaviours that are related to the different sexes and gender roles, but without knowing the meaning or consequences.

As a result of the evolution mentioned above, schools, particularly in northern and western European countries, have seen increased, intensified bullying based on the sex and gender roles of children and youngsters from the age of 5 all the way to the end of high school.

Previous experiences

As a steering committee member of YSAFE ("Youth Sexual Awareness for Europe" a youth network on sexual and reproductive health and rights established as a project of the International Planned Parenthood Federation European Network (IPPF EN)) I participated in the Regional Council meeting of IPPF EN in Madrid this summer of 2009. There I had the pleasure of discussing this subject of sexual bullying with other representatives from northern and western European countries, where the problem is progressing rapidly, with problematic negative development for those involved. Everyone at the steering committee felt strongly that one way to handle the issue of sexual bullying would be through the education of teachers from kindergarten, primary

school, secondary school and high school with curricula that allowed for active engagement in simulated bullying situations, combined with background history on sexual bullying and the psychological effect on children. While this method has been used with some success in some countries it has been shown not to be enough to tackle the problem. The discussion that followed at the meeting showed great initiatives from each country, which together holds the promise of an effective solution. Examples of various initiatives included:

- In Norway, in a town just outside Oslo, a high school teacher has been experimenting with a new teaching method for educating students about sex and sexual rights. Rather than formal lectures she focused on interactive education, setting up discussions in class and between classes on subjects taken from the IPPF statements on sexual rights. Students learned by being involved - preparing projects and activist campaigns on these subjects impacted significantly on how the youngsters behaved in front of each other and helped to lower the rate of sexual bullying. At the same time the participating students also signed up for YSAFE, which gave them a sense of seriousness and importance. High school students have an urge to be a part of an assembly with a goal to show their own capacity of doing something real. This could be a great way to address the problem of sexual bullying at a high school level, in combination with education of teachers, and participating students for peer education.
- In Denmark there has been national interest to stop sexual bullying. With support from local NGO's, radio stations, youth television, movie stars and musicians, Denmark launched a stop bullying campaign, focused primarily on students at the secondary school level, but also on primary school students. Education sessions were specifically designed to teach



Kalle Johannes Rose

educators how to address bullying issues from the kindergarten level onwards. Parents were also provided with educational sessions on how to minimize bullying. There has even been discussion about developing a certification system, where schools are graded in public on the education of teachers in the handling of bullying. In addition, the music TV/radio station “The Voice” had famous young musicians make statements about bullying and young celebrities made statements on youth used websites. Addressing the youth through this type of media to try and influence behaviour had very positive outcomes. Finally, a new method of using mobile technology to teach youth about sexual rights and sexual education way is being explored by the Danish Member Association of IPPF, perhaps in the form of a mobile telephone game. Former computer games for youth, that combined fun and sexual education, have previously been successful in Denmark at the end of the 1990’s. Regardless of whether the focus has been on ordinary bullying or on sexual education, the two are not completely separable and actions on each approach have shown and should show an effect on the other.

Solutions and ways forward

Psychologists, teachers, professors and volunteer workers all agree that the way to fight a problem like sexual bullying is by providing information and education about the issue at all levels, in a format that is relevant for the target audience. That is why it is extremely important to include peer youth educators to teach the youth in a “language” they understand. Using the language and slang of the youth helps establish equality and rapport. What remains more challenging is trying to establish when specific subject matter related to bullying should be taught, what the content should consist of and what media methods are appropriate to use for the task, specifically when considering

Definition of sexual bullying from WOMANKIND,

(<http://www.womankind.org.uk/sexual-bullying-definition.html>)

Any bullying behavior, whether physical or non-physical, that is based on a person’s sexuality or gender. It is when sexuality is used as a weapon by boys or by girls. It can be carried out to a person’s face, behind their back or by use of technology.

For example:

- Using words that refer to someone’s sexuality as a general put down (like calling something ‘gay’ to mean that it is not very good)
- Using sexual words to put someone down (like calling someone a ‘slut’)
- Making threats or jokes about serious and frightening subjects like rape
- Gossiping about someone’s sex life - including the use of graffiti
- Touching someone in a way that makes them feel uncomfortable
- Touching parts of someone’s body that they don’t want to be touched
- Forcing someone to act in a sexual way

that each country, region and town holds different cultural, economical, religious and social beliefs and behaviours.

My own advice for addressing the issue of sexual bullying would take into account the above and consist of the following: use the Norwegian experience and make the theme of sexual rights and health services a part of the high school volunteer services; use youth participating as activists to go out into secondary schools and become peer educators; teach about general human rights and sexual rights and services in the form of projects and discussion forums, not as lectures. If possible the use of youth media should and can have a positive effect on behaviour, as long as the use of communicators stays within the line of people that youth/children respect. For children at primary school there is a natural reluctance towards sexual education, but since sexual bullying exists even at this age (and where it may even be grounded) it will be necessary to take steps at this stage. A firm and

constant dialog with the parents can help the process.

Conclusion

To stop, change or slow down a process such as sexual bullying, steps have to be taken at national, regional and local levels, ideally synergistically. I hope that one day there will be a possibility to create a pop culture, which fights against bullying and sexual bullying, to secure harmony, social interactions and positive psychological progresses for the new generation of youth of all countries.

Kalle Johannes Rose, young person

Steering Committee Member of YSAFE

Master in Business Administration and Commercial Law

Copenhagen Business School

kallerosedk@gmail.com

ENGAGING AND INVOLVING YOUNG PEOPLE IN SEXUAL AND REPRODUCTIVE HEALTH

In 1994 the International Conference on Population and Development in Cairo cemented the concept that sexual and reproductive health (SRH) is a human right for all individuals, including young people. Since then many countries have developed strategies, policies and programmes that focus on SRH of adolescents and youth, including the development of quality youth friendly health services. Youth involvement is recognized as essential to the successful implementation of the above-mentioned activities. The focus of this article is Scotland's experience with engaging and involving young people in health service delivery.

Mystery shopping – A novel approach for youth led assessment of services

During the Healthy Respect Demonstration work in Lothian (see article page 24), a group of volunteers with Lesbian Gay Bisexual and Transgender (LGBT) Youth Scotland started a project to assess sexual health (SH) services for young people in the Lothian area. Dubbed the 'mystery shopping' exercise, nine organizations and eighteen services were assessed in total, none of which were aware of the assessment. The mystery shoppers' focused on five key subjects:

- access,
- appointments and waiting times,
- condition of waiting areas,
- staff and,
- quality and accuracy of information provided.

Under each heading was a list of questions, to be answered after every encounter, also referred to as the 'shop'. In the interests of collecting clearly measurable and comparable data, these were largely of a 'yes/no' nature, although almost every question encouraged 'shoppers' (those assessing the services) to include any significant comments or further explanation. Three distinct types of services were targeted. These were pharmacies, clinics and the c: card services (a type of dedicated service that provides condoms to young people free of charge). To read the full report go to <http://www.healthyrespect.co.uk/>

MIB: Mobile information bus in rural Scotland

Young people in rural areas identified that they needed and wanted appropriate

and quality information and support in a location that suited them. The MIB has the aim of working in partnership with other key agencies in order to address the following 5 objectives:

- identify areas of unmet need for young people,
- provide appropriate information and advice to young people,
- provide opportunities for self development,
- develop a programme of relevant activity and,
- ensure some of these activities are ongoing and sustainable in the community.

The MIB is primarily based within rural localities, where access to services and information is not as accessible for young people. Health and community planning workers staff the MIB. This works well as they have the local knowledge and know the young people. It is also an opportunity for youth workers to gain much needed training.

Since it began (in 2000) the MIB has visited 6 areas in Scotland including Strathisla, Fochabers, Speyside, Buckie, Forres and Lossiemouth. 6269 visits were made by young people between the ages of 12 to 18 years, providing an opportunity for young people to have somewhere to go, someone to listen to them, an activity to join in and an opportunity to take part in workshops and games. Interestingly, but perhaps not surprisingly 50% of the activity is health related (drugs, alcohol, sexual health). Workshops and health related discussions are popular, along with television, music and computer games.

The MIB works with communities to identify and sustain young people's

services. Most young people in rural areas want somewhere to hang out and something to do. In some rural areas we may only have 7 teenagers that night but it is important to remember that this may represent 90% of the youth population in that area. As a result numbers are not our main concern in rural areas.

Currently we are performing a critical review/consultation of the MIB service in Moray to support the ever-changing needs of young people. Findings indicate that the following factors have been key to the success of the MIB:

- unique (being the first of its kind) unit, that is comfortable and welcoming,
- highly trained staff,
- friendly, welcoming non judgmental environment,
- young people access the bus on their own initiative,
- reliable and consistent, it endeavors to secure effective partnership working,
- relaxed and informal atmosphere, where young people feel comfortable asking questions.
- equipped with approved educational resources and information that can be carried away,
- service users and providers review and evaluate the service on an ongoing basis and,
- recommendations from service users and providers are implemented to maximize the impact upon most at risk youth, such as those with poor SRH outcomes or disadvantaged socioeconomic status.



The Corner and the Peer Education Project

The Corner Young People's Health and Information Service is a health and information agency in Dundee, Scotland that provides services to young people aged 11-25 years old, funded in partnership with NHS Tayside, Dundee City Council and The Scottish Government. The Corner aims to work with young people in a manner that reflects the principles stated in the 'UN Convention on the Rights of the Child'. It strives to redress the inequalities experienced by young people through offering them assistance to develop skills and confidence and support to move forward and make positive choices in their lives. Services are all free, informal and confidential and include:

- full range of contraception and pregnancy testing services,
- information on a wide range of topics including drugs, housing and training,
- 1:1 support, legal advice, employment services,
- access to personal computers and broadband Internet,
- events and support/interest based opportunities (for both mixed groups and sex specific groups) focusing on a wide range of issues and needs, for example, drama, multiculturalism and mental health and,
- outreach with young people (Corner Carry-Out) in schools, colleges and community bases.

Peer education is a term widely used to describe a range of initiatives where people from a similar culture, background, age group or social status educate each other about a variety of issues. The Peer Education Project was set up to work in specific communities in Dundee as part of a range of approaches encouraging young people to make positive, healthy choices. The project's approach encourages a broad range of young people to participate in training and supporting young people to educate their peers. The model developed, which has personal and social development at its core, has created opportunities for young people to acquire

positive skills, contribute to their community, achieve accreditation and access a wider network of support that promotes resilience.

The project continues to develop links with young people, parents, community groups, police, schools, voluntary organizations and council departments to support peer-led health improvement of children and young people.

A 'VIEW' to improvement – young people training health professionals

Young people consistently report barriers to accessing primary health care services as:

- concerns about confidentiality,
- lack of information about services,
- unfriendly environment and staff and,
- language barriers (staff use jargon or overly 'adult' language) (1).

Recommendations encouraging the removal of these barriers have been supported by the WHO and have led to a call for the development of youth friendly health services worldwide. In 2001 the health services link worker post was created at The Corner Young People's Health and Information Service to work with front-line health care staff and ensure delivery and development of services that are appropriate and accessible for young people. This role 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 was to develop a young people friendly practice within health service settings. Various methods of developing and delivering youth friendly practice within the health service across the country were researched. The outcome of this was the development of training aimed at front-line health service staff called the VIEW (Values, RiGhts, ConfidEntiality, the LaW). Recognizing that primary health care remains one of the most accessible and available providers of a wide range of health services for young people, the aim of the training was to develop health workers awareness of youths needs and

issues and increase the provision of youth friendly health services. This is particularly relevant for Dundee where according to The Tayside Public Health Report 2006/07:

- Dundee City has the highest teenage pregnancy rates in Scotland,
- 3% of 13 year olds in Dundee City reported using drugs in the month prior to the report and,
- in Dundee City, 58% of 13 year olds and 82% of 15 year olds reported that they had ever had an alcoholic drink (2).

Partnership with Young Scot and young people

NHS Health Scotland has a unique historical partnership with the national youth information agency, Young Scot, which enable both organizations to bring evidenced based and youth friendly health messages and advice to young people via a website and phone line. The service is guided by a panel of young people as well as health topic experts to ensure information and advice is up to date and youth appropriate. Find out more at www.youngscotonfoline.org/channels/health/.

Please note that these are just a few examples of how we have engaged youth – for more examples please contact the author.

Nuala Healy
Health Improvement Programme
Manager (young people)
NHS Health Scotland
Email:
Nuala.Healy@health.scot.nhs.uk

References

1. Mcpherson A. 2005. ABC of adolescence: Adolescents in Health Service. *BMJ*, 2005; 330.
2. *Scottish Schools Adolescent Lifestyle and Substance Abuse Survey (SAL-SUS) – National Report 2008*. Ipsos MORI, ISD Scotland and NHS Health Scotland, 2009.

HUMAN AND ORGANIZATIONAL CAPACITY

In several European countries school health services for school children and university students exist, and professional organizations of the health care workers involved in these activities are united in the European Union of School and University Health and Medicine. The Union's goal is to increase awareness of governments and health service leaders of the importance of developing and improving health services to meet the rapidly changing health needs of pupils and students (1, 2).

For many decades Croatia has had a specialized organization dedicated to the prevention and protection of the health of school children and adolescents. Called "school medicine", this medical specialization was established in 1951 and postgraduate studies were developed in 1955. The specialization lasts three years encompassing knowledge and skills in clinical, as well as, in health promotion and health education areas. Postgraduate training lasts 4 months, as an obligatory part of the specialization. Recently, the new specialization programme titled "school and adolescent medicine" recommended the training duration be increased to four years. While these school health services have changed both in content and organizational structure with time, their focus has always been towards health promotion and prevention, particularly during vulnerable periods and events in children and adolescents' lifespan.

The goals of health care for school children and youth

Rising socio-economic inequalities in Croatia and the recent global recession have seen children and young people exposed to rising school demands, unemployment, in-loyal competition, dysfunctional families, violence, abuse and other forms of unfavourable life circumstances. Irresponsible sexual behaviours together with other forms of risk behaviours have negative consequences not only in youth but also have potential long-term effects on health later in life.

The health care for school children

and youth programme is oriented toward young people's undisturbed growth, physical, mental and emotional development. The main tasks are focused towards the complex contextual influences in childhood and adolescence that shape development. According to the national legislation framework in Croatia, organization of the specific health care for this population group is rooted in the basic legislation. The preventive programmes, for which the school health services are responsible, embrace different activities, such as systematic check ups, vaccination, counselling, health education and health promotion. School health services are available for each child or student during periods of education, free of charge, with no referrals required and no ethnic or other limitations. As school is seen as a place for learning, living and gaining experience in the life of many people, the contextual meaning of the school environment is of crucial importance for the school health services approach. Therefore, the activities are mainly planned and provided according to the school system, close to schools and university facilities, often targeting the class or school as a unit, using a health promoting approach where the role of school staff, pupils, parents and local community is taken into account (1,2).

Sexual health and school health services

Sexual education in Croatia exists as a cross-curricular subject in the school curriculum. School doctors and nurses provide health education activities on a regular basis and schedule (sexual maturation at age 11, the growth, development and sexually transmitted infections at age 13-16). The majority of activities occur in the class setting, either as lectures or using interactive approaches such as group work or guided discussion. The most recognizable school health services' activities are done through the counselling programme, which since 1998 have been organized within the school health service facilities. According to the main Rapid Assessment and Response

(RAR) findings (conducted in Croatia in 2001/2002) there was a recognized need for a foundation of youth friendly centres that would provide everything at a single place (for example, guidance centre on sexuality, counselling on relationships and communication problems, gynaecological service). These findings supported the further improvement of the existing school counselling services. As a result current sexual and reproductive health counselling covers early sexual intercourse, promiscuity, sexually transmitted infections, contraception, condoms use, teenage pregnancy, and sexual identity.

Areas of counselling

Besides reproductive health and risk behaviours, mental health, learning difficulties, and chronic illness are distinguished as separate areas of counselling. According to the Croatian Health Service Yearbook for 2007 (3) the number of counselling visits for pupils, parents and school staff at School Health Services grew from 77 843 in 1998 to 186 440 in 2007-2008. This increase is partly due to the change in school doctors' way of thinking, knowledge, and approach to work that occurred through postgraduate study in school health and various permanent in-service trainings.

The distribution of visits to the guidance service also reveals which topics pose the greatest burden to youth throughout their life cycle. Problems connected to chronic diseases, mental illness and learning difficulties are the leading issues in counselling primary school-aged children. For high school pupils, after chronic diseases, reproductive health issues were the second most frequent reason for counselling, whereas among university students reproductive health issues were the leading reasons for visits (Table 1).

Why perform counselling in school health services?

School health services that provide counselling hold a unique position in the health system as they are able to have significant impact on the health, includ-



Marina Kuzman



Ivana Pavić Šimetin

ing sexual and reproductive health, of children and adolescents. Rationale for this includes:

1. Young people may be unaware of their problems, afraid to seek help, or unable to make positive change without help. Contact to whole populations of primary, secondary and university students through activities such as systematic check ups and health education provide an opportunity to detect those at need for counselling who by themselves would not seek help. Therefore, school health work recognizes two crucial points in care: early detection and motivation to change. Early detection is improved through guidelines development (such as a guideline for obesity prevention (4)) and introduction of new screenings (such as mental health screening for high school pupils). Also, many school doctors and nurses are trained in the short motivation intervention "MOVE" which was introduced in Croatia in 2004 as part of "Strengthening the Croatian Capacity to Combat Drugs Trafficking and Drugs Abuse" in collaboration with German partners.
2. During the period of maturation, reproductive health risk behaviours are not an isolated event in the life of young people. According to our findings early sexual intercourse (at the age of 15 or earlier) was associated with complex risk and contextual factors, some of which are gender specific (5). This multiplicity of health problems requires a holistic approach to the young person's mental, emotional and physical health. School health services are able to provide this thanks to the school physicians' comprehensive approach and education.

Conclusion

The WHO European strategy for child and adolescent health and development (6) recommends youth friendly counselling and health services for reproductive health and other health issues. Our experience

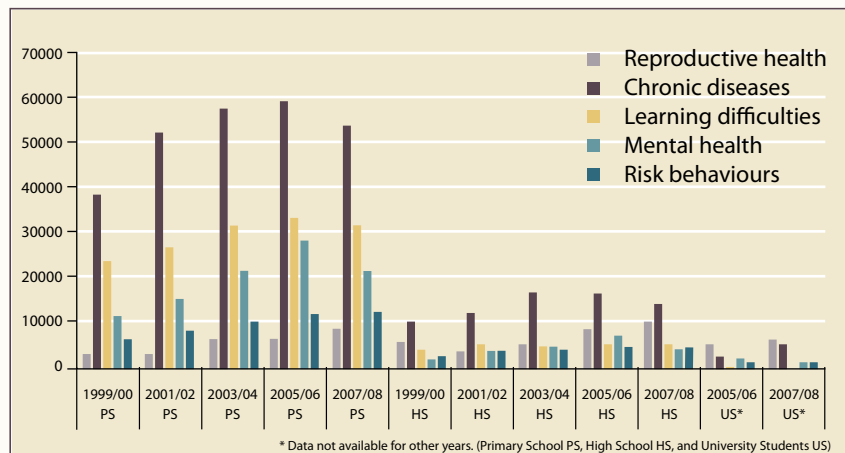


Table 1 Counselling in School Health Services 1999-2008, number of and reasons for visits.

has shown that the organization of counselling services within the framework of school health services, providing competent staff, open access and a youth friendly approach, can have a positive effect on the health of youth. Comprehensive research on youth friendly services organization and impact concluded that for developmental as well as epidemiological reasons, young people need youth-friendly models of primary care (7). There is enough evidence, as well as, broad expert consensus (1,2) to recommend that a priority for the future is to ensure that each country, state and locality has a policy to encourage provision of innovative and well-assessed youth-friendly services, whether part of existing school health services or new stand alone services.

Marina Kuzman, MD, PhD
Head, Youth Health Care and Drug Addiction Prevention Department
Croatian Institute of Public Health
marina.kuzman@zg.t-com.hr

Ivana Pavić Šimetin, MD
Croatian Institute of Public Health
ivana.pavic@hzjz.hr

References

1. European Union for School and University Health and Medicine. *The Dubrovnik Declaration on School Health Care in Europe, 13th EUSUHM Congress*, Dubrovnik, Croatia, 15 October 2005 URL: www.eusuhm.org
2. European Union for School and University Health and Medicine. *The Tampere Declaration on Student Health Care in Europe, 14th EUSUHM Congress*, Tampere, Finland, 6-9 June 2007 URL: www.eusuhm.org
3. *Croatian Health Service Yearbook 2007*, Croatian National Institute of Public Health, Zagreb, 1008; 172-186
4. Hoppenbrouwers K, Juresa V, Kuzman M et al (eds.). *Prevention of Overweight and Obesity in Childhood: A Guideline for School Health Care*, 2007. URL: www.eusuhm.org; 69-90
5. Kuzman M, Simetin Pavić I, Franelić Pejnović I. Early sexual intercourse and risk factors in Croatian adolescents. *Coll Antropol.* 2007; 31 Suppl 2:121-30.
6. European strategy for child and adolescent health and development. Copenhagen: WHO, 2005.
7. Tylee A, Haller DM, Graham T et al. Youth-friendly primary-care services: how are we doing and what more needs to be done? *Lancet* 2007; 365:1565-1573.

DEVELOPING YOUTH FRIENDLY PRIMARY CARE SERVICES IN BOSNIA & HERZEGOVINA

Family medicine implementation project in Bosnia and Herzegovina (FaMI project)

The Fondacija fami is an organization created with the support from the Swiss Agency for Development and Cooperation. Fondacija fami works on rebuilding and reorganizing health services in post-war Bosnia and Herzegovina through the development of a high quality primary care system. First phases of this project (FaMI phase 1-4) focused on training health professionals and implementing family medicine in Bosnia and Herzegovina. Fondacija fami is now focusing on the coordination and integration of health and social services into a coherent, cost-effective service provision, with a special emphasis on vulnerable groups (FaMI phase 5). Young people (10-25 years) are considered as a particularly vulnerable group in this country as they face major barriers in accessing health care. As most preventable causes of morbidity and mortality start in this period of life, financing interventions in this age group can provide long-term health and economical benefits. In addition, eastern and central European countries face societal changes that have great influence on young people's health: unemployment, post-war countries with children of traumatized parents, tobacco and alcohol misuse, growing epidemics of sexually transmitted infections (STI's) and rising intravenous drug abuse are just a few of the main challenges.

Bosnia and Herzegovina is mainly a rural country and access to specialized services remains scarce outside of major cities. Family medicine services provide an ideal point of care for the delivery of sexual and reproductive health (SRH) and other services to young people. As recently highlighted by the European forum for Primary Health Care, the provision of SRH through primary care has benefits such as easy accessibility, better coordination in service provision, integration of different health related problems within a consultation and a social-medical ap-



proach (1). In Bosnia and Herzegovina family medicine specialization offers education on STI management but no specific training on adolescent health issues.

Taking the above mentioned elements into consideration and building on the World Health Organization's (WHO) principles for the development of services that are available, accessible, acceptable and equitable for young people (youth friendly health services), Fondacija fami decided to support the development of youth friendly family medicine services in Bosnia and Herzegovina (FaMI phase 5) (2). Through a decade-long collaboration between Fondacija fami and Geneva University Hospitals, Swiss clinicians and researchers became involved in various projects as consultants. Physicians of the adolescent health unit in Geneva University Hospitals not only assisted in developing youth friendly family medicine services in Bosnia and Herzegovina, but also provided educational material for post-graduate education of health professionals and evaluated this development in order to provide essential evidence for use both locally and worldwide. Dr. Lena

Sanci, an Australian expert in adolescent health primary care was invited to join the project as an advisor (3). She has been leading projects in the field of "youth friendly primary care" for many years.

Implementation of youth friendly and health promotion activities within family medicine practices

Here we describe two projects to illustrate various aspects of FaMI supported activities in Bosnia and Herzegovina.

A. Community and school health education by family medicine teams

Since 2007, Orasje health centre has been conducting a large project to improve youth reproductive health (RH) in the municipality which consists of 25 000 inhabitants and 9 family medicine teams. In April 2008 the project was approved by the Federal Ministry of Health. This project employs family medicine teams, other health professionals, the local community, parents and young people, as well as, school services. Family medicine teams (doctors and nurses) attended



Anne Meynard



Daliborka Pejic



Dagmar M. Haller

modules of continuous education on various themes (RH and adolescent health general topics) and have then been teaching RH issues in school for 13-15 year old youth (See photo).

During focus groups, young people highlighted confidentiality issues as main barriers to accessing SRH services or condoms/contraceptives in this small rural conservative area.

The health centre is currently encouraging family medicine teams to register more data on youth accessing their services and opened a counselling centre also run by family medicine teams which includes phone and internet contacts and group sessions by school psychologists. School teachers will soon be integrating sex education in the school programmes. Ongoing project evaluation will allow data collection and better understanding of delivery of SRH services for young people in the local clinics.

B. The development of youth friendly family medicine services in the canton of Zenica: a cluster randomized controlled trial

Training of health professionals in adolescent health is a cornerstone for development of youth friendly services with now clear expert agreement on content and structure of such trainings. What makes the difference in the quality of services for young people is far less understood. Evaluation of the quality of services for young people is hampered by the lack of adequate tools to measure youth-friendly characteristics in practices. In order for their project to contribute to more concrete evidence in the development of youth friendly services, Fondacija fami team and their partners from Geneva University Hospitals chose to use a randomized trial design to evaluate the implementation of youth friendly family medicine services in the canton of Zenica which consists of 400 000 inhabitants. The project first focused on the development and validation of a tool to measure the youth friendliness of services for research purposes, followed by the evaluation of the effectiveness of an interven-

tion to improve the youth friendliness of family medicine services, in a randomized controlled trial using the validated tool.

In recent years, members of the Department of Child and Adolescent Health and Development at WHO headquarters in Geneva have created a toolkit, used internationally for quality control and improvement of youth friendliness of RH services (4). Adding elements from another tool developed for a youth friendly primary care project in Australia, and with contribution of an international group of experts, we adapted the WHO tool, adding new items addressing the variety of issues encountered in primary care (for example, nutrition, substance use and injury prevention). The trial will take place in family medicine services in ten municipalities of the canton of Zenica. The multimodal intervention will include training modules for family medicine teams, as well as different components addressing organizational aspects of the services, such as, confidentiality and information about services offered.

Conclusions

Bosnia and Herzegovina is facing major societal changes and health care reforms. SRH delivery for young people is a burning topic in many community projects including peer education, Internet help lines, youth clinics, NGO supported activities and school health. Accreditation of family medicine services for care of young people and preventive activities is currently in discussion and could give additional credit to these activities in the primary health care sector. Community projects like Orasje's project where family medicine teams are providing health education in schools maximize the use of existing resources and networks, which is especially important in rural isolated areas. The research project in the canton of Zenica will actively encourage collaboration between family medicine teams and community to increase visibility of offered services to the community for both young people and adults. It will also encourage implementation of system

changes for further adaptation of existing health care services to the needs of young people.

The trial will begin as these lines are published and results will be available by the second half of 2010. We hope it will contribute to a better understanding of quality care for young people.

Anne Meynard

Department of Child and Adolescent and Department of Community Medicine and Primary Care, Geneva University Hospitals and University of Geneva

Daliborka Pejic

Fondacija fami and Dobo Health centre, Bosnia & Herzegovina

Dagmar M. Haller

Department of Child and Adolescent and Department of Community Medicine and Primary Care, Geneva University Hospitals and University of Geneva

For correspondence contact: anne.meynard@hcuge.ch

The authors also wish to thank and acknowledge Tajiba Nurkic, Ana Sredic, Senad Huseinagic, Lena Sanci, Nicolas Perone and Françoise Narring, whose contributions were an essential part of the project.

References

1. Ketting EA., Akin A. The role of primary care in sexual and reproductive health in Europe. *Entre Nous*, 2009; 68:12-13.
2. McPherson A. Adolescents in primary care. *BMJ*, 2005; 330:465-7.
3. Tylee A Haller DM, Graham T et al. Youth-friendly primary-care services: how are we doing and what more needs to be done? *Lancet*, 2007;369:1565-73.
4. Kozhukhovskaya T. Assessing youth-friendly health services in the Russian Federation. *Entre Nous*, 2004; 58: 8-11.

HEALTHY RESPECT – A NATIONAL DEMONSTRATION PROJECT ON SEXUAL HEALTH AND YOUNG PEOPLE

Moray Paterson



What was the Healthy Respect Demonstration Project?

The Healthy Respect Demonstration Project (www.healthyrespect.co.uk) set out to create an environment that would lead to long-term improvements in the sexual health (SH) and wellbeing of young people aged 10-18 years, using a multi-faceted approach that linked existing providers of SH education, information and services. This consisted of two phases. Healthy Respect Phase One (HR1) began in 2001 and ended in 2004, and Healthy Respect Phase Two (HR2) began in 2005 and ended in March 2008.

HR2 aimed to demonstrate how working with young people from specific areas of Lothian (one of the 14 health regions in Scotland, that encompasses Edinburgh City, mid Lothian, east Lothian and west Lothian), using a multi-faceted approach, can enable them to develop a healthy respect and a positive attitude to their own sexuality and that of others. Healthy Respect's approach was evidence-informed, and linked up-to-date information with appropriate education and accessible services.

Working in partnership on SH: what we did

To deliver a range of activities across a variety of settings, HR2 developed partnerships with organizations and professionals who already worked with young people. These included:

- local authority partners in education, social work and community learning and development,
- NHS partners in general practice, family planning/SH and school nursing,
- voluntary sector partners in health, education and youth work and,
- partners in advertising and communications.

A partnership approach was used to integrate education, information and services, as the evidence suggests a multi-faceted

approach is the best way to achieve improvements for young people in sexual wellbeing.

Partnership network

A network of all the different partners involved in HR2 was established. To support this, a charter document was developed. This established the aspirations, guiding principles and values of the partnership, along with how the network would operate. In addition, a separate identity and brand was created for the network. The charter and brand highlighted the similarities between all of the organizations, as well as the mutual responsibilities of those involved.

A key element in the development of the charter was agreeing on values for the Healthy Respect partnership network. It was necessary to negotiate a set of values that everyone in the partnership could buy into, and identify their individual and organizational place within them. HR2 learned that having explicit values helped in the process of finding common ground where there were challenges to overcome.

Partner agreements

To formalize relationships, HR2 negotiated agreements with partner agencies. These agreements outlined key expectations and contributions from each partner, and identified lead contacts for each area of work. HR2 learned that it was necessary to build alliances with more than one person in each agency to engage staff at different levels, and to maintain communication if a key contact moved on. Partner agreements were negotiated for three-year periods, and were reviewed annually.

Network events

Twice a year, HR2 hosted partner events, bringing together all of the stakeholders within the Healthy Respect partnership network. These provided an opportunity to reflect on emerging issues and to share experiences. They also created a social space where members could network and build relationships with each other. HR2 learned that supporting partners

to present and share their own work at network events led to a shared sense of ownership of the network as a whole.

Communication

As well as face-to-face meetings, HR2 used a variety of communication channels to engage network members and share information. These included printed newsletters, e-bulletins and online forums. HR2 learned that communication needed to be two-way, with information going to and coming from partners. HR2 encouraged partners to make contributions and share information at events and in news bulletins. However, HR2 found it difficult to engage professionals in online forums, and found that professionals visited their website to access specific information rather than to chat.

Moray Paterson

Programme lead
NHS Health Scotland
Moray.paterson@health.scot.nhs.uk

Further reading

NHS Health Scotland. Evaluation of Healthy Respect Phase Two: Interim Report (Executive Summary). Edinburgh: NHS Health Scotland, 2008.

Healthy Respect's learning

- Organizational re-structuring and politics within partner agencies can influence their capacity to work in partnership. Healthy Respect Phase Two (HR2) learned that it was important to review partner agreements regularly.
- Individuals can move on or leave posts. HR2 learned that it was important to have more than one key contact in each partner agency.
- HR2 learned that the provision of funding could sometimes hamper projects, while those developed out of shared visions and shared contributions were often more valued and sustainable.

WALK THE TALK: SUPPORTING THE DELIVERY OF YOUTH FRIENDLY HEALTH SERVICES IN SCOTLAND



Nuala Healy

It is now widely acknowledged that young people face more complex health issues than their parents' generation. In 2002, the World Health Organization identified young people aged 10-24 as a priority group for health care providers. As a recent paper published in *The Lancet* highlighted, the need for young people to have youth-friendly models of primary care is now widely recognized around the world and enough is known about the barriers they face to merit policy and support for youth friendly health services(1).

Walk the Talk, a national initiative run by NHS Health Scotland, aims to support youth friendly health services across Scotland. The initiative aims to embed youth friendly practice within the mainstream NHS service offered to all Scottish people. The need for young people to be regarded as a priority group was underlined by the findings of research carried out on behalf of Walk the Talk (<http://www.walk-the-talk.org.uk/why-walk-the-talk/the-research.aspx>) and through ongoing dialogue with young people.

Walk the Talk recognizes that young people face a range of barriers in accessing health services and works to overcome these barriers in partnership with young people and professionals. Walk the Talk is supported by a broad partnership steering group including the Scottish Government, the Royal Colleges



Image 1

for General Practitioners and Nursing, the national youth work agency and NHS Education for Scotland (the agency responsible for professional education of health professionals).

Walk the Talk provides a series of national resources to support youth friendly health services, including an interactive website for professionals, a DVD made by young people on their experiences of health services, as well as, a short seven step guide to improving practice. The national website www.walk-the-talk.org is a central resource for information, research, tools and signposting. The site includes an interactive seven step audit for services to assess where improvements could be made. Visitors can watch a free short film produced by young people on their experiences and expectation of health services and this is now being used as part of a training session with healthcare workers. Professionals are then encouraged to take a seven step audit of their own service and the website provides them with feedback and pointers for improvement. Developing and maintaining a central national suite of resources to support practice continues and in 2009 Walk the Talk will begin distributing confidentiality posters to all health care settings. The poster which is the result of extensive consultation with young people and health professionals provides an eye catching image of a bunny with the



Image 2

message 'we keep it zipped' (see image 1), which was really appealing for young people who sometimes struggled with the concept of confidentiality and required reassurance that health care settings would respect their rights.

In 2008, Walk the Talk held a national conference for 200 health professionals, which included inputs from the WHO headquarters in Geneva, United Kingdom experts on youth health, as well as, young people who launched the Youth Voices DVD (available to watch on www.walk-the-talk.org). A cartoonist recorded the main themes of the day and these images can serve as helpful visual aids when educating healthcare workers on issues and solutions for healthcare and young people (also available free at www.walk-the-talk.org) (see image 2).

Walk the Talk's partnership with the Royal College of General Practitioners in Scotland has resulted in the programme becoming a criteria for their Quality Practice Award scheme. This will ensure that all general practitioner practices participating in this scheme will need to implement Walk the Talk principles to gain their award.

Nuala Healy
Health Improvement Programme
Manager (young people)
NHS Health Scotland
Nuala.Healy@health.scot.nhs.uk

References

1. Tylee A, Haller DM, Graham T et al. Youth-friendly primary-care services: how are we doing and what more needs to be done? *Lancet* 2007; 365:1565-1573.

QUALITY OF CARE IN ESTONIAN YOUTH CLINICS

The first youth clinics in Estonia were established at the beginning of the 1990s by local enthusiasts, and were without regular funding. Currently there a network of 17 clinics exists, which offer sexual health services free of charge for young women and men up to the age of 25 years. Contraceptive counselling, gynaecological and andrological examination, STI/HIV testing, pregnancy related counselling, sexual counselling, counselling after sexual violence and sexuality education lectures are offered in the clinics. Telephone and online counselling are also provided. If needed, referral to a specialist or other health care institution (for example for termination of pregnancy) is provided.

Work principles

All youth clinics work according to common principles: to help young people recognize their needs and rights, and to provide trustworthy information and counselling. Young people must feel secure, welcome and respected in the clinics. An integrated approach to problems is practiced, providing counselling in medical, psychological, as well as, social matters. Clinic specialists (doctor, midwife, nurse, and in some clinics also social worker and psychologist) work together as a team. To encourage visits, the atmosphere at the clinics is friendly and informal with a work routine that supports privacy. It has been kept in mind that youth clinics should be located in places accessible to young people, preferably separate from other health care establishments. The clinics are open at regular hours suited to young people and at least partly drop-in hours must be available.

Building up a network

In the 1990's the Estonian Family Planning Association (since 2005 Estonian Sexual Health Association, ESHA) took the clinics under its wing, organized training for the staff, and compiled and published sexuality education literature. In 2002 the Estonian Health Insurance Fund (EHIF) began to finance youth

clinic services (apart from sexuality education lectures) and currently the financing continues as part of a national HIV and AIDS strategy. The quality development stems to a large degree from the grassroots level. At the beginning of the governmental financing, the leading staff members emphasized the inner need for quality control as they felt that "youth clinics" must comply with measurable standards to justify their name. At the same time, the EHIF wanted to prevent the rising incidence of HIV and was interested in a network of clinics with strong management in order to form a trustworthy partnership. Thus, for the first time the clinics could take steps to achieve effective management of the network and improvement of the quality of services. Although the clinics operate as different legal bodies (as departments within larger health institutions, as private gynaecological practices or as practices set up especially for this service), they follow the same quality requirements and perform the same activities in order to improve the quality of care.

Quality of care on the network level

Regular financing enabled the ESHA to employ a part-time project manager and to form a workgroup of volunteers. The workgroup has eight members; among them are a youth representative, youth clinic managers with long-term experience, as well as, the previous and current project managers. The workgroup plays an important part in the planning of network management activities and their implementation. The activities of the clinics are regularly monitored, evaluated and, if necessary, adjusted. ESHA is also responsible for the advertising of the clinics in different media (audiovisual media, online-counselling, web-page, schools and other partner institutions). Clinic representatives are welcome to take part in workgroup meetings.

The youth clinics send statistical indicators to the ESHA every quarter, which enables the workgroup to analyze each clinic's work (Table 1). A joint quarterly report to the funding body includes

a summary of network management activities and an overview of the volume of services provided by each clinic. Each clinic receives feedback in which its actual activities are compared with those projected, those of other clinics and the project objectives. For example, records are kept of the number of medical tests and procedures conducted and the number of patients they are conducted on. Among other data, visitors' age, gender and working status is collected, which enables us to estimate which part of the target population is met or unmet by the service. Data about detected STI's and pregnancies helps to analyze the purpose of the visits, and to compare the results with the Estonian epidemiological situation. STI cases are registered in the general Estonian STI registration system. If, according to the gathered data, a clinic's practice diverges substantially from the others, an analysis of possible reasons is performed.

The founding of new clinics or the reorganization of existing ones is also assisted by the ESHA. New staff is provided with the opportunity of gaining practical guidance at one of the well-established clinics. Workgroup members visit the clinic frequently before it opens as well as afterwards to discuss with the staff members issues regarding their work. In 2008, EHIF ordered an independent analysis of the youth clinics' services from the centre for policy studies PRAXIS. As a result, youth clinics' quality improvement activities were set as a good example for other health promotion programmes.

Quality of care on the youth clinic level

Being part of a network means expecting the same style and quality of work from others. Therefore, written unified quality standards describe the principles of youth counselling and stipulations for their observance (Table 2). Quality standards are always ensured in the establishment of new clinics, as well as in the assessment of existing ones. The standards are regularly amended according to proposals from the clinics and the workgroup.



Kai Part



Triin Raudsepp



Helle Karro

Every year 1-2 clinics are supervised by three workgroup members, given feedback and recommendations for necessary changes, keeping in mind the common working principles. If a clinic is not working in accordance with the standards, ESHA has the right to suggest to the EHIF to discontinue the financing of that particular clinic. New clinics are supported with advice from more experienced clinics, and an evaluation of services is carried out at the end of their first year of activity.

Quality of care on the staff level

Two directions have been followed in the organization of training courses. The first provides yearly in-service training and guidance to existing staff members. There is a two-day summer training seminar every year on a particular topic, and this event serves as a social event as well. Additionally, regional supervision meetings take place 3-4 times a year. The second provides basic training in youth counselling (160 hours) to new workers and has been organized once with the help of ESHA.

Quality of care on the client level

To obtain feedback from young people, regular surveys (1996, 2002, 2007) have been conducted to assess satisfaction of the visitors. Since 2003 young people can also provide continuous feedback online at ESHA's web page. Feedback from both sources (surveys and online) is used for the development of activities for the network and for individual clinics. For example, TV and radio has been set up in some of the waiting rooms in order to prevent the clients in the waiting room overhearing the conversation in the counselling room. Additionally, telephone-counselling hours have been expanded, as the feedback from the clients indicated such a demand.

Different ways to reach several groups whose needs have not been met have been developed. For example, to reach youth living in rural areas, an online counselling service was initiated through the ESHA's web site. To increase the visits by young

males, several clinics provide separate hours for counselling for boys/young men. To improve access for non-ethnic Estonians, a web site and online counselling are available in Russian. The needs of school drop-outs, young drug users, and young homosexuals are still not fully met in the youth clinics. Identifying ways to reach these young people is an important task for us in the near future.

Although the activities to improve the quality of care in youth clinics have been divided between different levels in this article, the common goal of all the activities is the best possible sexual health service delivery for young people.

WHO has recently published an analytic case study of Estonian youth clinics, which is accessible at: http://webitpreview.who.int/entity/child_adolescent_health/documents/9789241598354/en/index.html

Kai Part

Gynaecologist and youth counsellor
Department of Obstetrics and Gynaecology, University of Tartu
Estonian Sexual Health Association
kai.part@kliinikum.ee

Triin Raudsepp

Programme manager
Estonian Sexual Health Association
Programme for Reproductive Health
Counselling and STI Prevention of Young People
triin@amor.ee

Helle Karro, MD

Professor
Department of Obstetrics and Gynaecology, University of Tartu
Estonian Sexual Health Association
helle.karro@kliinikum.ee

Table 1

Some statistical indicators collected quarterly from youth clinics.

- Number of visits.
- Distribution of contraceptive counselling/ STI testing/ sexual counselling visits.
- Number of first time visitors.
- Distribution of visitors by gender, age, working status.
- Number of STI tests performed (for Chlamydia, gonorrhoea, HIV, syphilis, genital herpes).
- Diagnosed cases of STI's.
- Number and age of pregnant visitors (including referrals for abortion, repeat abortions).
- Number of lectures and participants.
- Number of telephone counselling's.
- Advertising activities.

Table 2

Some compulsory requirements for youth clinics in the quality standard document.

- Availability of STI/HIV testing & counselling and contraception counselling.
- Facilities for diagnosing pregnancy.
- Availability of sexuality education lectures in the clinics.
- Team consisting of medical doctor and a midwife/nurse.
- Staff has passed courses on youth counselling.
- Organization of the rooms must support privacy.
- Access for disabled persons.
- Clear signs indicating the location of the clinic.
- Services are free of charge.
- Drop-in hours available.
- Free printed educational materials for the visitors.
- Possibility to give written feedback.
- Co-operation with ESHA, youth clinics' network, local schools.

REACHING MOST AT RISK ADOLESCENTS AND YOUTH – TAJIKISTAN’S EXPERIENCE

Currently the young people (aged 10-24 as defined by the United Nations) of Tajikistan make up about one third of its population and are an essential component of the country's human capital. The status of the health and well being of the adolescents and youth has serious implications for the future of the Tajik generation. In this respect Tajikistan faces many challenges: high rates of poverty, high youth unemployment, growing consumption of injection drugs, trends toward early marriage and poor public awareness of HIV/AIDS and STI prevention methods, coupled with widespread labor migration have created an environment in which HIV/AIDS is rapidly increasing over a short period of time, especially among the young population. While the HIV/AIDS epidemic in Tajikistan is currently a concentrated one, the youth (defined as those between the ages of 15-30 by the Youth Law of Tajikistan) remain most affected with approximately 70% of total numbers of people living with HIV/AIDS between the ages of 15-30 (1). Sentinel surveillance indicates injecting drug users and sex workers are the predominant at-risk youth category. In 2007, among sex workers, the prevalence of HIV was 1.8%, syphilis 12.6% and hepatitis C 4%. The prevalence of HIV among drug users was 19.4% (1).

In 2006, the Ministry of Education and Ministry of Health of the Republic of Tajikistan, in collaboration with UNICEF, CDC Atlanta, WHO headquarters and the WHO Regional Office for Europe, conducted the Global School based Health Survey (<http://www.who.int/chp/gshs/en/index.html>) to gain a better understanding of risk behaviours of adolescents aged 13-15. The study described the risk behaviour tendencies amongst adolescents and revealed the following: 1.6% of school children aged 13-15 had experienced injecting drug use, 12.6% of students seriously considered attempting suicide during the past 12 months and 10.7% of students were physically forced into sexual acts. In addition, only 3.7% of students aged 13-15 had a comprehensive level of HIV/AIDS knowledge (able to answer all five of the survey questions on HIV/AIDS transmission correctly) (2).

Using youth friendly health services to combat HIV/AIDS/STI's

In national legislation, there are several documents that address the health of young people and adolescents and have enabled the establishment of youth

friendly health services (YFHS) in existing health sector services (3). The YFHS supported by UNICEF and CARE International operates in five cities. They are designed to help achieve the goals of the National Strategy to Combat HIV/AIDS. The YFHS aimed to increase access by a targeted group to information, reduce practice of risky behaviours among most at-risk adolescents and youth (aged 15-24), including sexworkers, intravenous drug users, men who have sex with men, street children and school students and stabilize or reduce the prevalence of STI's and HIV/AIDS among these target groups. Intensive advocacy based on evidence resulted in significant achievements met during the project's first three years of operation. It included the establishment of a legal and regulatory framework that enabled at risk youth to have access to the confidential basic health services; the establishment of contacts between health service providers and at risks group through outreach approach; and the integration of the Universal Identification Code to keep track of the volume of most at risk adolescents visits, programme coverage, prevalence of



**Nisso
Kasymova**



STI's/HIV, use of supplies, and the volume of voluntary counselling and testing and treatments. Thus, in 2007, 47.7% of the target group was contacted through outreach, 26% visited the YFHS and 25% received counselling and an STI test (6% for HIV). In all, 18% of the target group were counselled and tested and, if testing positive, treated. 50% of the target group had comprehensive knowledge about HIV prevention, while 41% reported condom use during their most recent sexual encounter (4). The prevalence of STI's and HIV among those tested were 22.8% and 1.2% respectively (5).

Next steps

To date, only pilot activities have been carried out, as described above. This is an important step, but it is definitely not adequate enough to have an impact on young people in general. Nonetheless, the ground has been prepared for the project to be scaled up, together with national and local authorities and relevant partners, especially the at risk young people.

School has to be a part of, as well as, an entry point for the YFHS programme target groups coverage. The synergism

of both life skills based health education in schools, including an HIV/AIDS component, and access by young people to YFHS interventions will double the programme impact and help improve cost effectiveness and efficiency. Currently, however, most costs of the programme are financed by international agencies. Over the longer term, these will have to be incorporated into national budgets or otherwise covered by national resources. As a result, there is a need to define sustainability of YFHS scale up within the health system. The legal system also needs to be addressed. Current legislation allows provision of certain medical services to juveniles without parental constraint, while at the same time the age of consent differs across legislation. In addition, there is a need to repeal legal provisions for mandatory annual check ups and screening of all adolescents up to the age of 18 years (3). There is also a need to revise the provisional regulation governing YFHS operations in light of project experience. The project plans to conduct a thorough needs assessment for YFHS, to revise service criteria and standards that are currently in place, and based

on these two exercises to adapt and test WHO quality measurement tools.

Nisso Kasymova, PhD,
YPHDP and HIV/AIDS programme specialist
UNICEF Country Office, Tajikistan
nkasymova@unicef.org

References

1. *Surveillance Survey on HIV/AIDS in 2007*. Ministry of Health, Tajikistan: Republican AIDS Centre, 2008.
2. *Global School based Health Survey (GSHS) 2006 in Tajikistan*. Dushanbe, 2008.
3. Osipov K. *Developing Youth Friendly Health Services in the Republic of Tajikistan: Legal Aspects*. Dushanbe: UNICEF Country Office, 2007.
4. Currie C et al. (Eds). *Inequalities in young people's health. HBSC international report from the 2005/2006 survey*. Copenhagen: WHO, 2008.
5. Peart G. *YFHS bottleneck analysis. Experience of Three Pilot Cities in 2006 and 2007*. Dushanbe, UNICEF Country Office, 2007.



Sexually transmitted infections among adolescents – the need for adequate health services. Geneva: WHO and GTZ, 2005.

A global perspective on STI's in young people directed towards policy makers, health professionals and adolescents that aims to improve STI prevention and care strategies for youth.

Available in English at www.who.int/reproductivehealth/topics/adolescence/en/index.html



Investing in our future: a framework for accelerating action for the sexual and reproductive health of young people. WHO, 2006.

Directed towards programme managers and policy makers, it provides a framework for scaling up critical interventions in order to meet the needs of and improve the SRH of youth.

Available in English at www.who.int/reproductivehealth/publications/adolescence/929061240X/en/index.html



European strategy for child and adolescent health and development. Copenhagen: WHO, 2005.

The strategy provides a framework for improvement of child and adolescent health. A toolkit for implementation is also available.

Available in English and Russian at http://www.euro.who.int/childhealthdev/strategy/20060919_1



The health promoting school: international advances in theory, evaluation and practice. Copenhagen: Danish University of Education Press, 2005.

This book brings together recent international thinking on the links between education and health, and recent research evidence evaluating the processes and outcomes of health promoting schools initiatives.

Available in English at http://www.euro.who.int/InformationSources/Publications/Catalogue/20060419_1



Currie C et al (eds). Inequalities in young people's health: international report from the HBSC 2006/06 survey, (Health Policy for Children and Adolescents, No.5). Copenhagen: WHO, 2008.

A WHO collaborative cross-national study on patterns of health among young people aged 11, 13 and 15 years in 41 countries and regions across the WHO European Region and North America, it remains one of the best sources for comparative data on adolescent health and health behaviour.

Available in English at www.euro.who.int/InformationSources/Publications/Catalogue/20080616_1.



Generation of change: Young people and culture. Youth Supplement to UNFPA's State of the World Population Report 2008.

The third edition in a series, the youth supplements highlights the value and importance of recognizing and responding to the needs of youth.

Available in French, English, and Spanish at www.unfpa.org/public/cache/bypass/publications/pubs_youth



The Adolescence Experience In Depth: Using Data to Identify and Reach the Most Vulnerable Young People. UNFPA and Population Council, 2009.

A series of adolescent data guides that provides decision makers with data on most at risk adolescents.

Available in English at www.unfpa.org/public/publications/pid/3346 <http://www.unfpa.org/public/publications/pid/3346>.



Investing when it counts: Generating the evidence base for policies and programmes for very young adolescents. Population Council, UNFPA, UNICEF and UNAIDS, 2006.

This guidance document and toolkit presents methodologies that can be used to develop programmes and policies for adolescents aged 10-14 – a group that is often overlooked.

Available in English at www.unfpa.org/public/publications/pid/363 <http://www.unfpa.org/public/publications/pid/363>.



A reference guide to policies and practice. Sexuality education in Europe. Brussels, IPPF EN, 2006.

A guide to assist policy makers and governments develop better sexuality education, with data from 26 European countries.

Available in English at www.ippfen.org/en/Resources/Our+publications/default.htm <http://www.ippfen.org/en/Resources/Our+publications/default.htm>.



A guide for developing policies in sexual and reproductive health and rights of young people in Europe. Brussels: IPPF EN, 2007.

This policy guide provides a series of broad recommendations intended to guide policymakers and programmers in creating a more youth-friendly SRHR policy environment for young people.

Available in English at <http://www.ippfen.org/en/Resources/Our+publications/Policy+Guide.htm>

These are just a few of the excellent resources available for young people and all those involved with young people. More can be found at the following relevant websites:

IPPF European Network

- www.ippfen.org www.ippfen.org

WHO - www.who.int/topics/adolescent_health/en/

WHO Regional Office for Europe - www.euro.who.int/childhealthdev

UNFPA - www.unfpa.org/public/publications/pubs_youth

Y-Peer – www.youthpeer.org

Youth Sexual Awareness for Europe – www.ysafe.net

Allan Guttmacher Institute - www.guttmacher.org/

European training in effective adolescent care and health (EuTEACH)

– www.euteach.com

NHS Health Scotland - www.healthscotland.com

Web library on sexuality education

- www.contraception-esc.com/weblibrary

The aim of the web library is to provide background information and educational tools to professionals working in the field of sexual health promotion. It is designed to support best practice and contains a variety of international resources.

Entre Nous

*The European Magazine
for Sexual and Reproductive Health*

WHO Regional Office for Europe

Country Policies and Systems Unit

Scherfigsvej 8

DK-2100 Copenhagen Ø

Denmark

Tel: (+45) 3917 1602 or 1451

Fax: (+45) 3917 1818

[entrenous@euro.who.int.]

www.euro.who.int/entrenous



Entre Nous