Adolescence: building solid foundations for lifelong flourishing

Entre Nous

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WHO Regional Office for Europe
UN City
Marmorvej 51
DK-2100 Copenhagen Ø
Denmark
Tel.: +45 45 33 70 00
Fax: +45 45 33 70 01
www.euro.who.int/entrenous

Chief editor
Dr Gunta Lazdane
Editor
Dr Lisa Avery
Editorial assistant
Christopher Byrne
Layout
Kailow Graphic A/S
www.kailow.dk
Print
Kailow Graphic A/S

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ADOLESCENTS' SEXUAL AND REPRODUCTIVE HEALTH (SRH): EMPOWERING YOUNG PEOPLE TO REALIZE THEIR FULL POTENTIAL

Heimo Laakkonen

Adolescence is a decisive age for girls and boys around the world. What they experience during their teenage years shapes the direction of their lives and that of their families. Investments in adolescents' education and health are life-time investments that are likely to have positive effects on behaviours and lifestyles during their entire life course.

For many young people the mere onset of puberty that occurs during adolescence marks a time of heightened vulnerability. Girls in particular are at increased risk of leaving school prematurely, exposure to HIV and other sexually transmitted infections (STIs), early marriage and early pregnancy and sexual exploitation, coercion and violence. Boys also face some of these risks, albeit generally to a lesser extent. Adolescent girls often encounter greater difficulties than older women in accessing SRH care, including modern contraception and information on how to protect themselves from unintended pregnancy and STIs.

In Eastern Europe and Central Asia, adolescent birth rates have gone down since the mid-1990s but remain at a significantly higher level than those in Western Europe, with some countries even showing a slight increase in recent years. The highest rates are in Tajikistan, Georgia, Azerbaijan, Romania, Bulgaria, Turkey and Kyrgyzstan. This coincides with alarmingly low modern contraceptive usage rates in parts of the Region. In Albania, for example, only 29 per cent of sexually active unmarried women aged 15 to 19 report using modern methods of contraception, while almost half resort to unsafe traditional ones. As a result, the number of unintended pregnancies remains high, and in an environment where abortion continues to be used widely as a method of birth control, this also means that induced abortion rates are high. In the Republic of Moldova, there are 500 abortions for every 1000 live births among women under 20 years, by far the highest adolescent abortion rate in Europe.

Another consequence is the rapid increase in HIV and other STIs in the Region, affecting many young people, including adolescents. From 2001 to 2011, there has been a 20 per cent increase in HIV in the 15-24 age group, with most of these infections occurring among those who inject drugs, sell sex or engage in same-sex relations. Sexual transmission of HIV is increasing across the Region, becoming the most common route of infection. All sexually active young people are at increasing risk unless they use condoms correctly and consistently.

What is needed to address these challenges is a comprehensive approach. We need to advocate, based on evidence, for sound national laws, policies and programmes aimed at better health outcomes and safer behaviour by ensuring adolescents' access to SRH. When and where teenagers need the approval of their parents to access services, they will always face barriers in access to information, services and care.

We need to step up our efforts to demystify and promote sexuality education. Comprehensive sexuality education is not about teaching sex to teenagers. If anything, evidence shows that it teaches them to be responsible and postpone first sexual encounters.

We also need to increase the capacities of health services to cater for young people and reach out to those most in need. This means youth-friendly, quality services that adolescents are able and feel confident to take advantage of.

We need bold initiatives to reach the most vulnerable among the adolescents. This includes girls, teenagers belonging to minorities, orphans, young people living on the streets and those living in remote or rural areas.

Lastly, we need to involve adolescents themselves and empower them to participate in the decisions that affect their lives.

If we take such an encompassing approach to addressing the rights and needs of adolescents, we contribute to shaping a young generation that is empowered to realize their full potential – with far-reaching benefits for the prosperity and stability of the societies they live in.

The UNFPA works in all of these areas, together with its partners from governments, civil society, other UN agencies and importantly, young people themselves. The recent World Population Day on July 11 and the 2014 edition of the State of the World Population, UNFPA's yearly flagship publication, will focus on young people and contribute to making the case for the need to invest in adolescents and youth.

The increased attention to young people this year couldn't come at a better time, as we enter the final and decisive phase of deliberations on the post-2015 development agenda. Twenty years after the Cairo International Conference on Population and Development (ICPD), which firmly placed the rights and needs of individuals, including young people, at the heart of development, we can see that a lot of progress has been made. However, a recently published global survey on the implementation of the *Programme of Action* adopted in Cairo warned that the gains made cannot be sustained unless governments tackle the growing inequalities that hurt the poorest and most marginalized, with adolescents often being among the most vulnerable.

Investing in youth health and education and securing their human rights are essential to achieve the objectives of the *ICPD Programme of Action* and *Health 2020*, the European health policy framework. The young generation's health and well-being are important preconditions for delivering on sustainable development goals.

I hope that this edition of *Entre Nous*, with its focus on adolescents' health, will contribute to raising awareness of the challenges we face and chart out trajectories for concrete solutions.

Heimo Laakkonen,
Director,
UNFPA Regional Office for
Eastern Europe and Central Asia

THE HEALTH AND WELL-BEING OF CHILDREN AND ADOLESCENTS IS KEY FOR EVERY SOCIETY

Health 2020, the WHO policy framework for health and well-being in Europe, identifies that most children and adolescents in the WHO European Region have a high standard of health and well-being, but also highlights that despite substantial progress in recent decades, disparities in child health between and within countries, and population groups, persist. While select countries in the Region have infant and child mortality rates that are among the lowest in the world, mortality rates for children under five in other countries within the Region are 25 times higher than those with the lowest rate (1). Thus, even in affluent societies, improvement of health and well-being of children and adolescents will require a shift towards a whole-of-government approach and the introduction of comprehensive policies, often involving significant systemic changes, to ensure equitable distribution of health and well-being for this population group.

The WHO European child and adolescent health strategy, adopted by the 53 Member States of the European Region in 2005, focuses on inequalities, life-course approaches, cross-sector collaboration and participation of young people and the public in developing polices for children and young people (2). While these principles remain valid, since 2005 a richer evidence base has been developed and greater focus has been placed on child rights approaches, as well as on growing inequalities, especially within countries. This combined with greater focus on the lifecourse approach, the growing burden of noncommunicable disease and the decrease in well-being among adolescents are all factors which contributed to the need for a new WHO European strategy for child and adolescent heath.

A snapshot of the health and well being of children and adolescents in Europe

The Region has some of the highest prevalence rates of tobacco use among boys and (particularly) girls. The prevalence of weekly smoking increases significantly with age in most countries and regions: the increase between the ages of 11 and 15 years exceeds 15% in some countries (3). Second-hand smoke causes severe respiratory health problems such as asthma and reduced lung function in children.

Adolescent alcohol use is common in the Region. Young people may perceive alcohol as fulfilling social and personal needs, but it is closely associated with many causes of ill health, including injuries, smoking, illicit drug use and unprotected sex. Twenty-five per cent of boys and 17% of girls aged 15 report drinking alcohol at least once a week and almost one third report having been drunk at least twice (3).

Road traffic injuries are among the leading causes of death among children and young adults aged 5–19 years in the Region and the morbidity burden is many times higher. The leading causes of death due to unintentional injury are road crashes, drowning, poisoning and fires and falls. Unintentional injuries cause 42 000 deaths in 0–19-year-olds (3).

A considerable proportion of children and adolescents in many European countries do not meet recommended levels of physical activity. Surveys have shown that, on average, one in three children aged 6–9 years is overweight or obese. The prevalence of overweight (including obesity) in 11 and 13-year-olds varies from 5% to more than 25% in some countries (3). Over 60% of children who are overweight before puberty will be overweight in early adulthood, which will lead to the development of related diseases and chronic conditions such as cardiovascular disease and type 2 diabetes (3).

More than 10% of adolescents in the Region have some form of mental health problem, neuropsychiatric conditions being the leading cause of disability in young people (3). Major depressive disorders are the most frequent conditions in children and adolescents, followed by anxiety disorders, behaviour (conduct) disorders and substance-use disorders. The Region includes countries with the highest adolescent suicide rates in the world; suicide is among the leading causes of death among young people in many settings (3).

Twenty-five per cent of 15-year-olds have had sexual intercourse, but more than 30% in some countries are not using condoms or any other form of contraception, resulting in sexually transmitted infections (STIs) and unintended pregnancies (see Figure 1) (3).

A renewed promise – investing in children and adolescents

In developing a new child and adolescent health strategy four guiding principles were followed:

1) adopting a life-course approach;
2) using an evidence-informed approach;
3) promoting strong partnerships and intersectoral collaboration; and
4) adopting a rights-based approach.

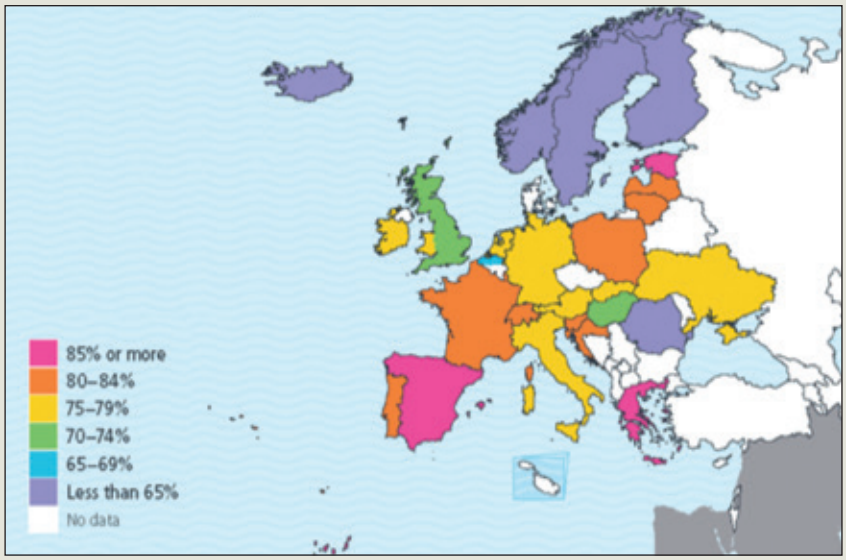
While it is still important to address the unfinished agenda of preventable death and infectious disease, attention is also directed at supporting growth though adolescence. The new strategy offers the opportunity for decision makers to introduce a stronger focus on health promotion policies and interventions.

The vision for the new strategy is that all children and adolescents born and/or growing up in the WHO European Region should:

- be visible to policy-makers, decision-makers and carers;
- be wanted children born to healthy mothers within nurturing families and communities;
- grow up free from poverty and deprivation;
- bond quickly and effectively with their mother, father, siblings and other important caregivers;
- be breastfed for the first six months and well nourished thereafter;
- receive the full programme of effective vaccination and health checks;
- be free of avoidable diseases and have full access to good-quality health services, including mental health services;

Vivian Barnekow

Figure 1. 15 year old girls who used a condom at last intercourse (3).



HBSC SURVEY 2009/2010.
HBSC teams provided disaggregated data for Belgium and the United Kingdom; these data appear in the map above.

- receive good, high-quality parenting;
- attend appropriate pre-schools and schools and become literate and numerate;
- have access to regular opportunities to take part in physical activity;
- have access to age and gender-appropriate health and sexuality information and support;
- remain free from harm from tobacco, alcohol and other substances;
- have access to a healthy, safe environment in communities, homes, pre-schools and schools;
- develop the confidence and skills to make informed choices and decisions and develop positive relationships;
- be empowered to participate in decisions about their health and well-being; and
- move into adulthood equipped with the necessary skills and competence to make positive contributions and enjoy a productive, healthy, happy life.

The lifecourse approach and adolescent health

WHO promotes good health at key stages of life, taking into account the need to address social determinants of health and gender, equity and human rights. Adolescence is such a key stage in life where major physical and mental changes are happening, as well as a period where other factors, such as entering into secondary education systems, have a major impact.

The lifecourse approach considers how health later in life is shaped by earlier experiences. This means not only considering the biomedical roots of adult health and illness during previous stages of the life course, but also the economic and social factors across the lifecourse that influence health. Present knowledge also reveals that investment in children and adolescents yields economic and social benefits beyond improved health outcomes. The more we provide young people with opportunities to experience and accumulate the positive effects of protective factors the more likely they are to achieve and sustain health and well-being in later life.

Referring to the strategy vision: *"all children and adolescents should have access to age- and gender-appropriate health and sexuality information and support"*.

It is essential that this age group has access to relevant information, as well as, confidential consultation to be able to avoid STIs and unwanted pregnancies. With this in mind, the WHO Regional Office for Europe has been working with various WHO Collaborating Centres and other partners to help develop sexuality education and implementation guidelines, as well as, youth friendly health services for school settings. A growing number of countries are already making use of these standards in their efforts to re-orient their health services for adolescents to: promote health and well-being; involve adolescents in decision making; and involve other relevant sectors in service provision. The new European child and adolescent health strategy will offer additional inspiration for this process.

Vivian Barnekow,
a.i. Programme Manager,
Child and Adolescent Health and Development,
Noncommunicable disease and life-course,
WHO Regional Office for Europe,
vbr@euro.who.int

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EUROPEAN YOUTH ACT FOR CHANGE

Human rights standards have established that all people must be enabled to attain the highest possible level of health and exercise their right to bodily autonomy. However, adolescents and youth, within Europe and across the globe, still face many barriers to the realization of their sexual and reproductive health and rights (SRHR).

Age of consent laws, which criminalize the sexuality of adolescents and young people, have far-reaching implications for their access to sexual and reproductive health (SRH) information, education and confidential services. Social stigma surrounding adolescent sexuality can perpetuate discriminatory attitudes among service providers. Additionally, families and communities systematically violate the rights of adolescents through harmful cultural practices that are prevalent at this age, including female genital mutilation (FGM) and early and forced marriages.

These are just some of the factors that contribute to pervasive violation of young people's rights and prevent them from accessing information and services on the same basis as other people. It is no wonder that globally poor SRH is often rooted in adolescence.

However, these challenges are motivating a growing number of adolescents and young people to work towards the realization of SRHR for all. These youth-led initiatives have taken many forms- from providing peer education in their local communities, to advocating for improved recognition of the specific needs of adolescents and youth at a policy level. This article explores some best practice examples of how youth advocates and activists are working to bring about social change in relation to young people's SRHR.

Image 1: Young participants from the European Dialogue for Youth Rights project, a partnership between YouAct, Choice for Youth and Sexuality, Restless Development and Hope XXL.

Raising awareness and increasing visibility - YSAFE: Youth Sexual Awareness for Europe

YSAFE is a youth network on SRHR under the umbrella of the International Planned Parenthood Federation European Network (IPPF EN). YSAFE focuses on empowering youth participation in decision-making and programme implementation at the Member Association (MA) and Regional levels. We bring together young people from MAs in 38 countries across Europe and Central Asia to share knowledge, work together on projects and intitiatives and develop their capacities as young advocates.

YSAFE believes that young people are the best activists and advocates for youth SRHR and for this reason must be present and visible. In 2014, as part of youth involvement and participation in decision-making processes, YSAFE members participated in several conferences and events. In April three YSAFE members attended the 47th session of the Commission on Population and Development in New York to advocate for the inclusion of stronger language on SRHR in the outcome document. Prioritizing comprehensive sexuality education in the post-2015 development agenda was also an advocacy priority.

In May YSAFE's Coordinator headed to Sri Lanka to attend the World Conference on Youth for roundtable discussions on themes such as ending systematic inequalities, where comprehensive sexuality education in and out of schools was identified as a crucial prevention measure. The Colombo Declaration emerging from the conference further recognized the importance of sexuality education in realizing SRHR.

YSAFE made its presence felt by participating in IPPF's Global Day of Action in May, which launched the #IDecide petition, as part of the Vision2020 campaign. YSAFE was active on social media, gathering actions and pictures from member associations. YSAFE also participated in a conference in Strasbourg on the theme of reaffirming the right to sexuality education. One YSAFE member was a key speaker and presented YSAFE's advocacy activities around the Estrela SRHR report last year. Alongside other conference participants, YSAFE provided input to a joint statement, which will be officially launched in the following months.

Putting youth rights on the agenda of European policy makers – YouAct: European Youth Network on SRHR

Since the start of this year, YouAct has partnered with three youth-led organizations on the European Dialogue for Youth Rights project. The project brought together young advocates from across Europe for targeted advocacy training and to develop strategies for addressing key barriers to realizing adolescent and youth SRHR. Participants developed a joint statement calling on decision-makers to prioritize the SRHR of young people in the Post-2015 framework, with specific calls regarding the importance of comprehensive sexuality education to realizing the human rights of adolescents and youth.

YouAct supported these young advocates to put their skills into action and reach out to decision makers and share the joint statement. In advance of European Elections in May, participants made their voices heard by communicating their calls to more than 85 Members of the European Parliament (MEPs) from across all political groupings.

Participants also met face-to-face with MEPs, candidates, parliamentary staff and the heads of national youth ministries, while others inspired peers to take action and vote. One project participant even decided to stand in her local election. Lucy Bannister, 20, who lives in Manchester, ran as a Green Party candidate for her local council. When asked about her motivation to become a young decision-maker Lucy said:

"I think the European Dialogue for Youth Rights project influenced me to

Ivy Miltiadou

Peter Mladenov

Grace Wilentz

Martyna Zimniewska

stand and has made me really motivated to get involved in elections and to encourage other youth to register and vote. I've seen the importance of our involvement with Europe and the power of the European Parliament. The training and the follow up since then has given me reassurance that young people have the drive to be involved with politics and that this involvement can be influential. I am so pleased with the impact we've made. I hope that we can do even more when the new parliament is elected."

In addition to national-level advocacy, in March YouAct organized a hearing at the European Parliament on the topic of comprehensive sexuality education, co-hosted with Slovakian MEP Katarina Nevedalova. Eight young participants from the project led the hearing, delivering presentations on topics ranging from integrating FGM prevention into sexuality education programming and models of sexuality education for reaching young people out of schools.

Youth leaders implementing programmes on the ground – Youth Peer Education Network (Y-Peer)

The Y-Peer Network started more than ten years ago as an initiative of the United Nations Population Fund (UNFPA). Since then, it has transformed into a youth-led network of young people and organizations based in more than 40 countries throughout Eastern Europe, Central Asia, the Arab States and the Asia-Pacific region.

Y-PEER provides training based on standardized peer education methodologies, using original tools developed and delivered by facilitators who are experts in peer education and HIV prevention. By using the peer-to-peer approach, Y-Peer succeeds in empowering young people to engage in the HIV response worldwide and to make more informed choices regarding their health and sexuality, especially through out-reach to broad constituencies and key populations.

Peer education has proven to be an effective and innovative means of delivering sexuality education. Experts refer to peer education as a model that leads to more positive behaviours, changes social norms and supports young people and adults to work in partnership. Its unique methodology is characterized by different techniques of non-formal education, which suit formal and non-formal education settings.

In Bulgaria peer education has become mainstreamed across the activities of key actors delivering sexuality education in the country. There are 18 NGOs working in partnership with the Ministry of Health through the National Programme for prevention and control of HIV/AIDS, funded by the Global Fund to fight AIDS Tuberculosis and Malaria. These 18 NGOs have established youth-clubs where peer educators receive training, deliver peer education sessions and conduct field work among their peers with a special focus on marginalized young people, including young people in care and Roma youth. To give an idea of the reach of the programme- each year a training of trainers is organized for more than 200 young people aged 15-19.

In Georgia, Y-PEER activities have been implemented by a national youth-led organization, which reaches high school and university students. The Y-PEER Georgia network actively conducts regional workshops targeting cities and rural areas where young people have limited access to SRH information and services.

Translating needs on the ground into policy recommendations – Astra Youth

ASTRA Youth is an informal network of young advocates from Central and Eastern Europe and the Balkans. The network is dedicated to advocating for implementation of evidence-based, non-discriminatory comprehensive sexuality education in the school curriculum. Astra also advocates for youth friendly services and the participation of young people in policy development and decision-making processes relating to their SRHR.

Though many countries in the Region are European Union Member States, progress remains slow and uneven when it comes to the degree to which SRHR have been realized. Conservative influences and major funding withdrawals have undermined the ability of advocates and trainers to respond to efforts aimed at limiting the rights of women, girls and young people.

In the face of these challenges, the Astra Network's member organizations persist in providing peer education and youth friendly services, producing publications and resources, raising awareness and engaging in dialogue with local decision-makers in order to increase understanding of the benefits of comprehensive sexuality education to young people and their societies. In the Region there is a marked lack of sexuality education programmes in schools and NGOs are often the only source where young people can access evidence-based, non-judgmental information on sexuality.

ASTRA Youth has also been actively bringing the perspectives of young people from Central and Eastern Europe to the ICPD+20 review and Post-2015 processes with the aim of ensuring that the voice of youth and adolescents from the Region is heard and reflected now and in the future. This is a crucial time when decisions about the priorities for future global development are being made. Youth advocacy is particularly crucial in order to fully support the inclusion of adolescents and youth in the agenda and to urge decision-makers to ensure young people's rights are guaranteed in the international commitments.

Ivy Miltiadou,
Coordinator,
YSAFE

Peter Mladenov,
Y-Peer International Coordinator

Grace Wilentz,
Coordinator,
YouAct

Martyna Zimniewska,
Coordinator,
Astra Youth

Correspondence to: Grace@YouAct.org

INTERVIEW WITH THE UNFPA EXECUTIVE DIRECTOR AND UNDER-SECRETARY-GENERAL OF THE UNITED NATIONS: DR BABATUNDE OSOTIMEHIN

Twenty years after Cairo, where do we stand on reaching the goal of ensuring universal access to sexual and reproductive health (SRH) for young people?

We have made tremendous progress during the past 20 years when it comes to young people. The Global Survey Report published earlier this year confirms this: for example, there have been vast gains in girls' primary education, a 45 per cent decline in maternal death and a record number of countries that have laws banning child marriage. Adolescent childbearing is on the decline in many countries, in particular where girls' secondary school enrolment rates are going up. Young people have become more powerful, interconnected agents of change, drivers of development and play an important role in advancing SRH among their peers.

We must build on these successes as we tackle the many challenges that remain. For example, every day 39 000 girls are married before their 18th birthday and 20 000 girls age 17 and below give birth in developing countries. The reasons are evident: gender inequality, sexual violence and coercion and national policies restricting access to reproductive health services and comprehensive information. Poor and marginalized young people face particular difficulties. We must also increase our attention to younger girls aged 14 and below, as they often get overlooked by a development community traditionally focusing on 15-19-year-olds.

In Eastern Europe and Central Asia, where do you see the main challenges in reaching this goal?

Compared to other parts of the world, young people in Eastern Europe and Central Asia often have significantly greater opportunities, with better access to education and health care. This does not mean that there are no problems in the Region, in particular for young people in rural areas or those belonging to ethnic minorities or other marginalized groups. In spite of economic growth, disparities are widening in the Region; it is important to translate economic growth into human capital development by investing in youth and particularly, in youth health.

We see an alarmingly low modern contraceptive prevalence rate in parts of the Region – lower in several cases than the average in the world's least developed countries, also among young people. In Albania, for example, 45 per cent of sexually active young women aged 15-24 rely on traditional methods of contraception while just 13 per cent use modern methods. Many more teenagers become pregnant in Eastern Europe and Central Asia than they do in Western Europe. Abortion rates in the Region are among the highest in the world. Secondary infertility is rampant, with almost one in five women who have already given birth unable to become pregnant again.

This Region is also one of the few parts of the world where the HIV epidemic remains on the rise, especially among young people. From 2001 to 2011, there has been a 20 per cent increase in HIV in the 15-24 age group, with most of these infections occurring among those who inject drugs, sell sex or engage in same-sex relations. Women are also increasingly becoming infected, now accounting for 40 per cent of new HIV cases compared with just 24 per cent 10 years ago. Again young women are particularly at risk: from 2001 to 2010 the percentage of women aged 15-24 living with HIV more than doubled, with high rates of infection observed within partners of migrant workers, sex workers and women who inject drugs or partners of men who inject. Moreover, the number of HIV positive pregnancies in the Region has doubled during the past five years. Urgent attention is also required to tackle harmful practices, such as early marriages and gender-biased prenatal sex selection in some Eastern European and Central Asian countries.

What is UNFPA doing to address these challenges?

Young people are a main focus of UNFPA's work, not only in Eastern Europe and Central Asia, but globally as well. Investing today in the health and education of young people is the best and most cost-effective way to improve the lives of future generations. We advocate laws and policies that improve opportunities for young people. In Georgia, for example, we contributed advice and evidence that helped formulate the new

Jens-Hagen Eschen-baecher

youth policy adopted by the Government, which is expected to make young people a development priority for the country.

We promote comprehensive sexuality education for young people, often in the face of considerable resistance. Unfortunately, old myths about sexuality education remain widespread in this Region and we still have a lot of work to do to convince policy makers and parents that age-appropriate information empowers young people to practice safer behaviour and have responsible relationships in order to protect themselves from alcohol, drugs, unintended pregnancy, HIV and other sexually transmitted infections (STIs). We help in the building of youth-friendly SRH services, with a focus on the most vulnerable, such as the poor, the Roma and other minorities. We also promote the participation of young people in decision-making on issues that affect them.

What do governments in the Region need to do?

I believe what we need in the Region is a stronger focus on the rights of young people and a better understanding that investing in the human capital of adolescents and youth – including in their SRH – is key not only for ensuring a better future for young people, but also for the welfare of society as a whole. There still is too much attention being paid to increasing population numbers, in particular in the low-fertility countries of Eastern Europe. This can lead to attempts to limit the reproductive choices of young people, including access to SRH services and information. Evidence shows that such attempts are not only likely to fail in increasing fertility, they also can have devastating effects by driving up maternal death, adolescent pregnancy, unsafe abortion, secondary infertility and rates of STIs, including HIV. Only if we create the conditions for all young people to have full access to integrated, comprehensive, quality SRH services and information will we be able to realize their rights and unlock their full potential for society.

Interview conducted by:

Jens-Hagen Eschenbaecher,
Regional Communications Adviser,
UNFPA Regional Office for Eastern Europe and Central Asia,
eschenbaecher@unfpa.org

Photo credit: Nezih Tavlas/UNFPA

ADOLESCENT AND YOUTH POLICIES: STATEMENTS FROM 6 COUNTRIES

Ms Lola Bobokh-odjieva

Tajikistan

In Tajikistan more than 70% of the population is under 30 years old. The legislation of the Republic of Tajikistan guarantees access of youth to health services, reproductive health (RH), family planning and healthy lifestyle education.

The Government of Tajikistan considers RH as a key priority of health care reform. Healthy Lifestyle Education and Family Planning is a part of the National Strategic Plan on RH and the Law on Reproductive Health and Rights promotes a human rights approach to RH. A number of legislative and policy documents (i.e. the Law on Gender Equality, Domestic Violence Law, National Reproductive Health Strategy, National Youth Health Development Strategy and National Youth Policy Document) are among those with a special focus on adolescents and their health. Remarkably, youth are one of the three target groups of the National Strategic Plan for the Prevention of HIV/AIDS, as 70% of registered HIV cases are among 15-24 year old people.

Targeted efforts have been taken to improve the access of youth to health services and information. National legislation and policies were reviewed to identify and remove barriers to access; youth friendly health services (YFHS) were established; health care providers have been and continue to be trained in YFHS approaches; YFHS national standards are in the process of development; and enhanced data collection and reliability has been prioritized in order to address the real needs of young people, especially those living in remote areas and most at risk youth, including adolescent girls.

Our government today involves young people to partake in development of future global and local strategies which affect their lives, thus ensuring better reflection of their needs in these documents and their further participation in materializing of those life goals.

Ms Lola Bobokhodjieva,
First Deputy Minister of Health and Social Protection of Population of the Republic of Tajikistan

Ukraine

Ukrainian youth is the best in the world. It was youth with its active civic position who proved to the whole world that it is capable of framing state policy and defining the future of our country.

The Ministry of Youth and Sports of Ukraine aims to meaningfully involve youth in its work at all levels. Currently, the Ministry is developing the concept of the State Social Programme "Youth of Ukraine for the period 2015-2020" and we plan to widely involve civil society in this process, including discussion of the concept with the young people of Ukraine. Jointly with our international partners we also plan to develop and introduce a special training programme, to build capacity, called the "Youth worker" for youth leaders and our civil servants who work with youth.

All our work is based on international best practices and with support from our international partners. We are grateful to the UN system in Ukraine, in particular to the UNFPA Country Office, for their support and joint work on a number of projects aimed at improving youth policy in Ukraine and bringing it closer to the European standards. The new strategy envisages establishing close bilateral cooperation with major EU countries and international organizations interested in supporting youth policy reform in Ukraine. In this regard, key partners of the Government in addressing urgent problems of young people are youth organizations that, as civil society actors, are increasingly beginning to be involved in addressing youth issues.

Mr Dmytro Bulatov,
Minister of Youth and Sports of Ukraine

Albania

Young people now have more opportunities and choices than their parents did, but they face more risks as well. The Albanian government is reacting by adapting its policies to the new challenges. Approaches include:

Strategic Document on Reproductive Health 2009-2015. Its goal is to ensure that Albanian adolescents be healthy, educated, socially responsible and live and express themselves in a safe and supporting environment. Healthy lifestyle among adolescents is promoted through; peer education programmes for youth in schools; community prevention of unwanted pregnancies and other sexual risky behaviours; and training to improve health provider professional capacities and knowledge on youth and adolescents.

HIV/AIDS Control Strategy 2008-2014. The strategy focuses on promotion of safe behaviours and HIV risk reduction of adolescents and young people through innovative approaches such as: establishment of a supportive environment and elimination of barriers which hinder prevention programmes to reach youngsters; involvement of schools, families and communities; collaboration with civil society; and counselling and testing centres for youth.

Enhanced school curriculum. During the last four years the school curriculum has been significantly enriched with topics covering healthy life skills, prevention of HIV/AIDS and other STIs, healthy nutrition, physical activity and prevention of drug abuse etc.

Strengthened research. National school based surveys such as the Youth Risky Behaviours Survey and Adverse Childhood Experiences Prevalence have been developed and implemented, providing important information on youth and adolescent risky sexual behaviour to policy makers, programme managers and NGOs.

Mrs Milva Ekonomi,
Deputy Minister,
Ministry of Health of Albania

Belarus

The preservation and improvement of human health, including adolescent and youth SRH, is stipulated by law, including the Constitution of the Republic of Belarus, the Laws of the Republic of Belarus "On Health Care", "On Demographic Security", "On the Child's Rights", "On State Social Privileges, Rights and

Mr Dmytro Bulatov

Mrs Milva Ekonomi

Mr V. I. Zharko

Mr Levan Kipiani

Mr Andrei Usatii

Guarantees for Certain Categories of Citizens", and "On the Prevention of Disability and Rehabilitation of Persons with Disabilities." Belarus has also developed and approved the National Plan of Action on the Improvement of the Situation of Children and Protection of their Rights for 2012-2016, the National Plan of Action on Gender Equality for 2011-2015, the National Programme on Demographic Security for 2011-2015 and the State Programme for HIV Prevention for 2011-2015.

Owing to a clear strategy outlined in these legislative acts, Belarus has been able to implement a number of programmes that benefit youth and adolescent SRH. Active work on the prevention of HIV, STIs, abortions, as well as on issues related to contraception, is conducted among adolescents and young adults at Youth Friendly Centres that were established with the active support of the UNFPA. The centres also provide medical and psychological assistance to young people in a crisis situation and victims of violence. Courses on the fundamentals of SRH have been introduced in the curricula of colleges and universities and active work is conducted in the field of sexual violence prevention with health professionals represented on the National Committee for the Prevention of Child Pornography and Violence Promotion. Additionally, for the purposes of maintaining and improving the SRH of young people, the Ministry of Health actively cooperates with NGOs and international organizations and works closely with other ministries and agencies in Belarus to develop healthy life skills, proper reproductive behaviour and responsible parenthood skills.

Mr V. I. Zharko,
Minister of Health,
Republic of Belarus

Georgia

Evidence based advocacy, primarily supported by UNFPA Georgia and other partners, helped to generate political will for making youth development a priority in Georgia, which resulted in the development of the National Youth Policy in 2013-2014. Strong national ownership and leadership of the Ministry of Sport and Youth Affairs of Georgia made it possible to put this issue high on the public agenda.

The National Youth Policy, adopted by the Government of Georgia in March 2014, highlights the unified vision on the role of the youth and their development needs and provides an appropriate action plan for four strategic fields. The document was developed by the Inter-agency Coordinating Council composed of representatives of all line ministries, parliament members, youth NGOs and representatives of UNFPA and UNICEF, with the Ministry of Sport and Youth Affairs leading the process. The document has been widely discussed and validated with youth representatives.

The National Youth Policy will help enable young people to fulfill their potential with regard to education, employment and mobility, health, participation, special assistance and protection. It clearly defines the Government's commitment and vision towards youth development, including: opportunities for youth involvement in social, economic, cultural and political life; appropriate and high quality education; employment and professional growth opportunities for youth; increased awareness of young people on civil rights and duties; establishment of a safe and secure environment for young people; protection of their rights; and support of young people with special needs.

Under the health domain the policy aims to improve awareness about SRH and rights through formal and informal education and to increase access to quality SRH services for young people. The National Youth Policy reflects the principles adopted by the 1994 International Conference on Population and Development.

Mr Levan Kipiani,
Minister of Sport and Youth Affairs of Georgia

Republic of Moldova

Adolescents and young people aged 10-24 years make up nearly one quarter of the total population in the Republic of Moldova. Moldovan young people continue to face various issues related to their health and development which limit their full potential to contribute to society: sexual health issues (STIs and HIV, unwanted pregnancies and abortions), substance use (excessive alcohol consumption, smoking, illicit drug use), mental health and suicides; high levels of unemployment; lack of non-formal development opportunities; criminality; and the pressures and impact of migration.

To effectively solve the above problems, the Government has set as a priority health and development of adolescents/youth in a number of strategic and policy documents such as the National Health Policy for the 2007-2021 and the National Reproductive Health Strategy for 2005-2015. The National Strategy on Child and Adolescent Health and Development for 2014-2024 and National Strategy for the Development of Youth Sector for the years 2014-2020 are in the process of finalization. In 2012 adoption of the new Reproductive Health Law represented a major achievement as it guarantees equal access of adolescents to SRH services and the implementation of effective programmes of SRH education in the mandatory school curriculum.

In line with these policy documents, with support of the WHO, UNICEF, Swiss Development Cooperation Office and UNFPA, 38 Youth Friendly Health Centres (YFHC) were created which provide free access for young people of the country, including especially vulnerable adolescents and most-at-risk young people, for health services based on YFHS quality standards. As a result, access to YFHS has increased from 5% in 2011 to 15% in 2013. In regions where YFHCs have been operating for more than five years the adolescent birth rate is 2 times lower than in regions where there were no such services.

Mr Andrei Usatii,
Minister of Health of the Republic of Moldova

SEXUAL AND REPRODUCTIVE HEALTH (SRH) AMONG ADOLESCENTS AND YOUTH IN EASTERN EUROPE AND CENTRAL ASIA

Adolescence is a period of human development during which minds, bodies, values and personalities are being formed. These changes occur simultaneously, though at different paces for each adolescent, with gender, social and environmental factors often impacting the transition. Unless SRH and rights are supported and upheld across a range of dimensions and within a range of settings, young people's lives will be negatively impacted. Similarly, if young people lack access to opportunities to learn, contribute and explore; if they are not considered meaningful partners in and contributors to the societies in which they live; if they suffer from violence, are forced to marry early, or are deprived of resources, the negative outcomes of adolescent and youth development are almost always evident in the unfavourable status of their SRH.

In spite of the significant progress observed in achieving the Millennium Development Goals and International Conference on Population and Development targets by the countries in Eastern Europe and Central Asia (EECA), challenges remain in the area of adolescent and youth SRH. In many countries GDP growth has not translated into reduced health inequalities or improved SRH of young people. Significant barriers still exist to accessing SRH information and services, disproportionately affecting marginalized adolescents and youth and leading to higher rates of unintended pregnancies and abortions, as well as a growing incidence of sexually transmitted infections (STIs) and HIV infection in the Region. Adolescent marriages and pregnancies continue to be a challenge in many countries of the Region, where there are large disparities both between and within countries in terms of adolescent birth rates (see Figure 1). Adolescent girls who become pregnant are not physically and emotionally mature enough to become mothers; they face a higher risk of pregnancy and delivery complications and they are more likely to drop out of school, limiting their future opportunities for education, employment, participation and development. The persistence of harmful traditions and practices in some countries of the Region, including bride kidnapping and child marriage, is considered a major factor contributing to high adolescent pregnancy rates in these countries.

Disparities and inequities are a result and manifestation of vulnerability and they are even more pronounced in minority populations, such as Roma. The birth rates among Roma adolescents are much higher compared to their peers in the general population in all EECA countries: 145 vs. 8 in Bosnia and Herzegovina, 158 vs. 24 in Serbia and 94 vs. 13 in the former Yugoslav Republic of Macedonia (1).

Adolescents face difficulties in obtaining family planning services and are therefore at risk of unintended pregnancies and unsafe abortions. Pregnancies among adolescents are more likely to end in abortion in Eastern Europe than in Central Asia: e.g. for every one pregnancy among adolescents in the Republic of Moldova that ends in abortion, there are two that result in a live birth, whereas in Tajikistan, for every one pregnancy that ends in abortion there are 50 that result in a live birth (see Figure 2) (2).

These striking numbers are illustrative of a generally higher unmet need for family planning, caused by limited access to youth-friendly SRH services and information. Unsafe abortions among teenage girls contribute substantially to lasting SRH problems and even maternal deaths. Given the relatively young age of marriage and first pregnancy in the Region, access to postpartum family planning is even more critical: secondary infertility in EECA is most likely to be a consequence of unsafe abortions and particularly of high post-abortion infection rates. The growing incidence of STIs, including HIV, could be prevented in the Region if the barriers to comprehensive sexuality education and youth-oriented family planning services were to be eliminated. The above-mentioned factors have made EECA one of the few parts of the world where the HIV epidemic continues to grow, with one-third of new HIV infections occurring in young people aged 15–24 and young girls the most vulnerable: HIV prevalence among females aged 15-24 in EECA (0.2%) is twice as high than among males (0.1%) of the same age group (3).

UNFPA: Taking an Integrated Approach to Adolescent and Youth SRHR in EECA

By '*Delivering a world where every pregnancy is wanted, every childbirth is safe and every young person's potential is fulfilled,*' UNFPA places young people at the centre of its programme. Through the implementation of its Adolescents and Youth Strategy, UNFPA advocates for prioritizing young people within the global development agenda. At both the global and regional levels, UNFPA has operationalized the Adolescents and Youth Cluster, a mechanism of its integrated approach to young people as actors in social change, not only as beneficiaries of social programmes. UNFPA advocates for governments to invest in their countries' futures by providing young people with quality education, decent employment, effective livelihood skills and access to SRH and comprehensive sexuality education. Such investments should also take gender equality into account as an essential factor impacting young people's development and that of their families, communities and countries.

The Regional Programme in Eastern Europe and Central Asia 2014-2017, aligned with the UNFPA Strategic Plan (2014-2017) and tailored to country priorities, aims to improve the SRH of adolescents and youth by streamlining its programme around the five key elements of the UNFPA Strategy on Adolescents and Youth:

Promoting comprehensive sexuality education (CSE)

UNFPA supports efforts by countries to deliver CSE, both in and out of school; UNFPA works with Youth Peer Education Network, Y-PEER, launched 10 years ago in EECA countries and utilizing innova-

Tamar Khoma-suridze

Teymur Seyidov

Marija Vasileva-Blazev

Figure 1: Adolescent birth rates in the EECA region by country (1).

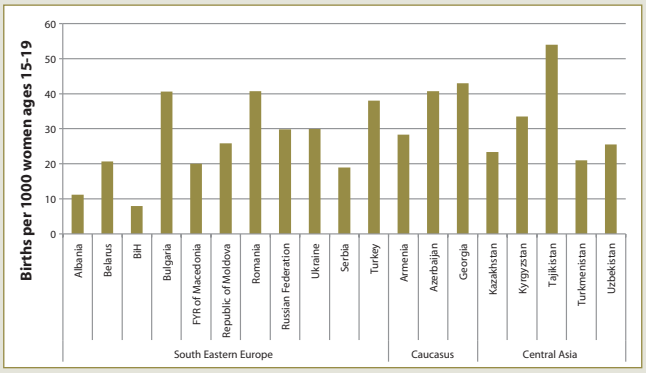
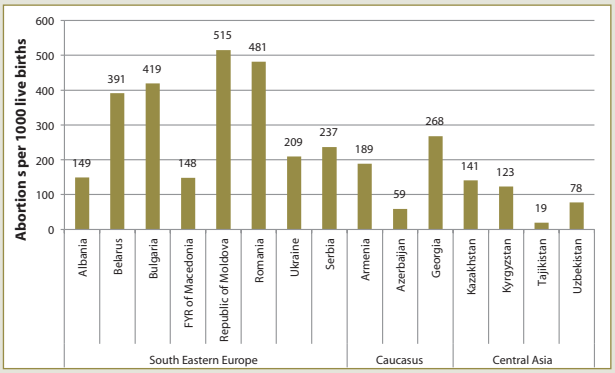


Figure 2: Abortion ratios among women below age 20, by country, 2008-2011 (2).



tive approaches—such as websites and social media, theatre performances and celebrity spokespeople—to reach young people with quality information and messages about SRH through peer education. The EECA regional Y-PEER International Peer Education Training and Research Centre–Sofia, established in 2007, is a sustainable partnerships network of young professionals from the Region paired with adult experts to conduct regular trainings and research, offer opportunities for internships and serves as the regional hub of UNFPA EECARO and the global UNFPA Y-PEER network.

Improving access to SRH services

UNFPA advocates for and supports national capacities for youth-oriented services, so that they are available, accessible, acceptable and affordable for young people. In EECA, UNFPA strives for the creation of an enabling policy environment and national capacities for the establishment and delivery of youth-friendly SRH services across the entire Region, including integrated SRH/HIV services to young people at higher risk of HIV/STI exposure. Support provided by the International Children's Centre in Ankara, Turkey, delivers regional capacity-building activities for improved SRH services to adolescents and youth.

Promoting youth leadership and participation

UNFPA creates opportunities for young people to act as leaders and advocates for the policies and decisions that will affect their lives. It has also helped bring together parliamentarians and young activists to discuss youth policies in the Region. The 2013 UNFPA EECARO publication *Youth Participation in Policy Dialogue and Programming* presents good practices on the involvement of young people in programming and policy dialogue, advocacy efforts and national development processes in the Region.

Providing data on youth to advocates and policy-makers

UNFPA assists countries in generating and analysing population and development data that can be used to support and advocate for effective policies and programmes. UNFPA works with governments, applying the data and evidence to policy dialogue; as a result of such cooperation many countries in the Region developed or updated national policies that address adolescent and youth SRH.

Reaching out to marginalized and disadvantaged adolescents and youth, especially girls

Young women and girls are commonly at the highest risk of poor SRH, violence and exploitation, including through sex work and early marriage. In Kyrgyzstan, UNFPA has contributed to improved legislation addressing child marriages as well as the prevention of HIV among sex workers. In south-eastern Europe, the agency has successfully worked to help raise awareness about child marriage and early pregnancies among Roma communities.

Tamar Khomasuridze, MD, PhD,
SRH Advisor,
UNFPA Regional Office for Eastern Europe and Central Asia

Teymur Seyidov, MD, PhD,
SRH Programme Specialist,
UNFPA Regional Office for Eastern Europe and Central Asia

Marija Vasileva-Blazev,
Youth Programme Specialist,
UNFPA Regional Office for Eastern Europe and Central Asia

Correspondence to: khomasuridze@unfpa.org

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SCHOOL-BASED SEXUALITY EDUCATION IN EASTERN EUROPE AND CENTRAL ASIA (EECA)

Introduction

In 2013 the UNESCO Moscow Office commissioned an assessment of policies and practices related to the delivery of prevention education in Eastern Europe and Central Asia*. The aim was to better understand the actual situation, achievements and gaps and to inform discussion among multiple stakeholders about how to enhance the quality and expand the reach of education programmes. The assessment findings were published in a report titled *Prevention Education in Eastern Europe and Central Asia: A review of Policies and Practices* (1) and discussed with representatives of national ministries of education, civil society organizations and UN partners at a regional conference *Education for Health, Development and Participation* held on December 3-4, 2013 in Kiev, Ukraine. The present article is based on this assessment report.

Findings

In many Eastern European and Central Asian countries the education sector is mandated to equip children and young people with knowledge, skills and attitudes to live safely and healthy. This constitutes grounds for school-based health and life skills education that among other topics touches upon sexual and reproductive health (SRH) issues. Elements of sexuality education, including HIV prevention and SRH, are found in school curricula in all the EECA countries. However, there are significant differences between countries in the approaches, content and scale to which HIV and SRH education is delivered. None of the countries calls such education 'sexuality education'. Usually such programmes are identified as 'health education', 'healthy life style' or 'life safety' education. As they primarily aim to prevent risky behaviour and its negative consequences, they can be considered as 'prevention education' programmes.

In most countries, basic information about human reproduction is provided in secondary school (Grades 5–9) within the mandatory science subject biology. In three countries (the Russian Federation, Belarus and Kazakhstan), HIV is briefly discussed together with other infectious diseases and health threats within the mandatory subject 'Basics of Life Safety' in Grades 7–9. Heavily focused on safety at home and on the road, as well as man-made and natural disasters, this subject teaches students to provide first aid, resolve conflicts, cope with stress, eat a healthy diet and encourages safe living free from alcohol, tobacco, drugs, HIV and other infectious diseases. However, 'Basics of Life Safety' misses out important topics related to SRH and does not discuss non-health related aspects of sexuality at all.

Three countries in the Region have developed relatively comprehensive curricula for compulsory SRH education, which is packaged as life skills-based health education in secondary school. In Grades 7–9 in Ukraine and in Grades 8–11 in Armenia and the Republic of Moldova students learn not only about romantic relationships, love, marriage, family and parenting, but also discover facts about psychosexual development, puberty, gender, gender-based violence and harassment. They also study topics related to reproductive health, prevention of sexually transmitted infections (STIs), HIV and unintended pregnancy, tolerance and non-discrimination of people living with HIV.

In many countries, optional courses and extracurricular activities are the main providers of HIV and SRH knowledge in schools. In Kazakhstan, students in Grades 5–9 learn about these topics from a non-mandatory course 'Health and Life Skills in School'. In Uzbekistan, the same topics are included in a course entitled 'Basics of Healthy Generation'. In Kyrgyzstan, these issues are discussed at 'Culture of Health' lessons delivered in Grades 1–8. The Russian Federation also uses various non-compulsory life skills and health education courses, which cover some HIV and SRH themes.

Human anatomy and physiology are generally studied in Grades 8–9, when students are 13–15 years old. At this age, they receive the bulk of information about reproductive health, STIs, HIV and substance abuse prevention, as well as learning about communication, decision-making and conflict resolution skills. Compulsory life skills and health education is continued in upper grades (10–11) only in Armenia and the Republic of Moldova. The absence of compulsory subjects that deliver HIV and SRH education in upper secondary school means that certain important aspects of SRH topics that are appropriate for discussion with 16–17-year-old students are missed, as they are not studied in the previous grades.

The number of learning hours dedicated to healthy lifestyle and SRH education varies from country to country and across levels of education. In Belarus five to seven hours per year is spent on the topic; in Armenia 14 hours per year; and in Ukraine 35 hours per year in Grades 1–7 and 17 hours per year in Grades 8–9 are dedicated to this area.

Most countries avoid discussion of 'sensitive' issues at school. For example, reproductive anatomy and physiology is well represented in biology, but adolescents' psychosexual development and sexual behaviour are barely addressed. Students learn about communication skills and conflict resolution but rarely discuss in the classroom how to make decisions about sexual behaviour and negotiate safer practices. Human rights and gender equality are discussed in many subjects, but reproductive and sexual rights are hardly mentioned; gender diversity is silenced or presented to students as something "deviant" or "abnormal".

In 2010-2012, four countries (Kazakhstan, Kyrgyzstan, the Republic of Moldova and the Russian Federation) reported that 81 to 92.4 per cent of schools provided life skills-based HIV education in 2006–2011 (2). However, in the same years, only 31.9 to 38.2 per cent of young people aged 15–24 could correctly identify the means of HIV prevention and dispel the main misconceptions about its transmission in these countries. In Uzbekistan, 100 per cent of schools claimed to teach HIV prevention in 2009, while only

Tigran Yepoyan

12.5 per cent of surveyed young people displayed correct knowledge about HIV. More coherence between school coverage and learning outcomes is found in Belarus (over 96.8 per cent of low secondary schools covered and 62.7 per cent of young people have good knowledge) and Ukraine (58.7 per cent of schools and 39.9 per cent of young people).

The mismatch between the coverage and learning outcomes may be attributed to data collection limitations and could be explained by irregular and inconsistent teaching, an inadequate number of lessons and deductive, teacher-centred instruction. It also reflects the complexity of measuring the effectiveness of programmes that address HIV and SRH education.

Many of these programmes are currently non-examinable. Making them examinable would definitely make them rank more highly, but would also turn them into another knowledge-based subject that students have to memorize to obtain good grades. Students may demonstrate good knowledge of facts and give socially accepted answers, but may attach little value to their learning and therefore may not apply it.

While the value of life skills and health education in schools is not questioned, in many countries the discussion of sexual and reproductive rights and behaviour is considered to be inappropriate in a classroom context. Parents' objections to sexuality education are often used to explain its absence in schools. However, the recent *2011 Russia's Population Reproductive Health Survey Report* revealed that 88 per cent of Russian women aged 15–44 support sexuality education in schools in order to provide knowledge about pregnancy, STIs, contraception and other issues (3). Contentious opinions about the goals and benefits of SRH education hamper the decisions to make it compulsory and to invest sufficient resources to take it to national scale, according to agreed standards.

Future efforts

The main challenge for the EECA countries lies in overcoming the prejudices against sexuality education and developing an evidence-informed, rights-based and gender-responsive approach to comprehensive life skills and health education which fully integrates SRH related topics and discusses them in a culturally appropriate, age-sequenced and participatory manner.

Internationally agreed standards on sexuality education (4, 5) are available for countries to: revise existing curricula and develop new teaching and learning materials; strengthen teacher preparation and support; and scale up parent sensitization and orientation to increase parents' awareness about and support to school-based sexuality education. Furthermore, well recognized peer education approaches need to be institutionalized in curriculum-based prevention education and extracurricular activities with a special focus on adolescent and young key populations. Additionally, given the popularity of the Internet and social media networks among adolescents and young people, ICT-based learning and awareness raising tools should be wider used to augment school-based programmes.

At the same time, national capacities for the systematic collection and analysis of data disaggregated by age and sex on adolescents' and youth SRH related knowledge, behaviour and health outcomes have to be enhanced to inform relevant policy and practice development in health and education sectors.

Last but not least, it is important to establish and improve linkages and referral mechanisms between educational institutions and youth-friendly SRH services and eliminate legal and institutional barriers for young people to access such services.

Tigran Yepoyan,
UNESCO Regional HIV and AIDS Adviser for Eastern Europe and Central Asia,
t.yepoyan@unesco.org

*Countries covered by the assessment: include Armenia, Azerbaijan, Belarus, Kazakhstan, Kyrgyzstan, the Republic of Moldova, Russian Federation, Tajikistan, Ukraine and Uzbekistan.

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USING EVALUATION RESULTS TO IMPROVE SERVICES – THE CASE OF THE REPUBLIC OF MOLDOVA

Introduction

A core principle of quality improvement is that what is not measured cannot be improved. Therefore, evaluation has been an integral part of the longstanding agreement that a priority for each country, district and municipality should be to provide "well assessed youth-friendly services" (1). However, assessment and evaluation by itself may have little or no effect. Only the use of the evaluation results to implement activities to improve quality of care can achieve improved outcomes and lead to the desired impact. This article describes how the Republic of Moldova has established youth friendly health services (YFHS) and used the results of an external evaluation to improve programming and ultimately the quality of services for young people.

The Moldovan Context

The Republic of Moldova is a small, landlocked country in south-eastern Europe that was established as an independent state in 1991 after the breakdown of the Soviet Union. The transition period has been difficult from a socioeconomic point of view and the Republic of Moldova remains the poorest country in Europe (2). Almost a quarter of the population of 3.5 million are young people aged 10-24. This age group has been particularly affected by the rapid changes of society during the transition years, with deaths from injuries, trauma and intoxications, levels of STIs including HIV, early pregnancy and mental difficulties and disorders rising alarmingly (3). On-going massive emigration of the workforce, particularly among the rural population, has meant that thousands of Moldovan children and adolescents are growing up without the care of one or both of their parents.

YFHS in the Republic of Moldova

To address these challenges and provide adolescents and young people with the services they need, the Republic of Moldova set up YFHS in 2001, with initially 3 Youth Friendly Health Centres (YFHC) and then 12 donor-funded YFHCs in 2005. In 2009 the Ministry of Health developed the following 6 national quality standards for YFHS: 1) young people know when and where they can request healthcare; 2) young people have easy access to the health services they need and they also find them acceptable; 3) health service providers maintain the confidentiality and respect the privacy of young people; 4) health service providers mobilize the community to promote YFHS; 5) healthcare providers offer effective and comprehensive services in line with the real needs of young people; and 6) all young people have equal access to health services (4).

It defined a package of services to be provided at each of the YFHCs to prevent and respond to developmental, nutritional, sexual and reproductive health (SRH) and mental health needs, as well as, needs resulting from violence. While all young people are targeted, special efforts are made to reach young people who are particularly vulnerable.

An NGO "Health for Youth", which runs a very successful centre providing health services to adolescents in Chisinau, is the flagship of the programme and the main impetus behind the scale up of services in collaboration with UNICEF Moldova and the Ministry of Health. The Swiss Development Cooperation (SDC) has been providing substantial financial support for the past three years through a project called "Healthy generation". Activities implemented through this project included: the horizontal scale up of services with the establishment of at least one YFHC in each of the 35 districts (38 centres in total by the end of 2013); capacity building of health care providers from YFHCs and primary health care services in adolescent health and quality improvement approaches; vertical scaling up actions to improve the regulatory basis, the financing mechanisms and the monitoring system; and the integration of adolescent health in in-service training and postgraduate education.

The SDC commissioned an external evaluation of the Healthy Generation Project at the end of its first phase (2011-2014) to assess progress and achievements and to draw lessons to inform planning and identify priorities for the second phase.

Methodology of the evaluation

The external evaluation followed a systematic evaluation framework to evaluate specific questions that targeted the input, process, output, outcome, impact and cost elements of YFHS (see Figure 1). Methods used to answer these questions included: a desk review of relevant documents; analysis of available secondary data (national and UN databases and surveys, previous studies on coverage and cost); and key informant interviews. In a purposeful sample of six YFHCs quality assessments using a semi-structured questionnaire, client exit interviews and observation tools were also performed.

Findings of the evaluation

The findings of the evaluation are beyond the scope of this article and can be found elsewhere (5). However, important findings that led to immediate improvement activities include the following three results:

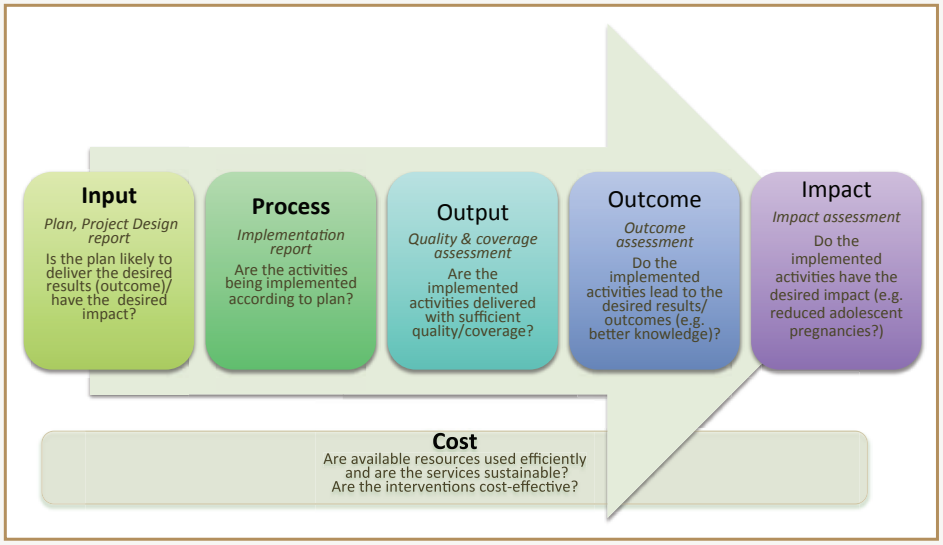
1. YFHCs were not fully mandated to deliver the full package of services and therefore services were often limited to the provision of information and counselling. While a specific package of services for YFHCs had been defined by the Ministry of Health, the centres were not authorized to provide the clinical services to adolescents and had to refer their clients to specialized centres for diagnostic and treatment services. This counteracted the very idea of YFHS being accessible in one place and guaranteeing confidentiality and privacy.
2. The YFHCs that were initially founded as NGOs and then subsequently designated as YFHCs by the Ministry of Health outperformed newer public sector centres in relation to the six national quality standards, particularly in relation to friendliness and acceptability. This raised questions on how to best increase motivation and

Susanne Carai

Stela Bivol

Venka-traman Chandra-Mouli

Figure 1: Evaluation Framework for Youth-Friendly-Health-Services (YFHS)



improve health worker performance in the public sector.

3. While the explicitly stated objective of the project was to "improve the SRH of young men and women in Moldova *particularly those vulnerable and most at risk*" no specific activities were planned or carried out to reach vulnerable and most at risk adolescents. Furthermore, no data was available on how many adolescents reached by the project may belong to this group.

Use of the results

A few months after the evaluation, a workshop with all stakeholders was held in Chisinau to review the findings and plan for the next phase. At this point the Ministry of Health had already addressed the first finding and put in place the necessary regulations to mandate the YFHCs to provide the full package of services.

During the workshop available evidence on how to best improve health worker performance was reviewed and a collaborative approach was included in the plan for the next phase. This approach includes training and regular problem solving sessions that bring together staff from the YFHCs to share experience and lessons learned, as well as, pairing better with less well performing centres together to share and learn. In this regard, an operational research component was developed to establish whether the performance of currently poorly performing centres will increase if they are linked with better performing centres through job-shadowing, supportive supervision and collaborative learning sessions.

When carrying out a root cause analysis during the planning workshop on why the currently offered health services seem not to serve people in vulnerable situations, it became apparent that there is no consensus on who and where vulnerable people are. A phased approach was devised to improve the programme´s performance in relation to meeting the needs of young people in vulnerable situations. The first phase involves identifying vulnerable groups (studying available data sources on who and where they are and mapping institutionalized young people), followed by a second phase of implementation of outreach services with real services on the spot (e.g. provision of medication, HIV testing, condoms) by experienced outreach workers. The second phase also focuses on supporting adolescents with parents abroad through the establishment of self-help groups and the establishment and expansion of a network of temporary placement centres. As for the activities to improve health worker performance, a planned operational research component may be able to document increased programme performance.

Conclusion

Despite many challenges, the implementers of YFHS in the Republic of Moldova were able to improve services and programme performance by using evaluation results genuinely. The joint review helped to identify and implement activities needed to provide adolescents with improved services. The use of the evaluation framework helped to structure the evaluation and subsequent planning to address identified limitations. It pinpointed issues that seem so obvious that they might have gone unnoticed by a less-structured approach.

Susanne Carai, MD, MA,
Consultant

Stela Bivol, MD, MPH,
Consultant

Venkatraman Chandra-Mouli, MBBS, MSc,
Scientist,
Adolescent Sexual and Reproductive Health,
WHO headquarters, Geneva,

Correspondance to: sc@dischi.de

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YOUTH, SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) ACTIVISM AND SOCIAL MEDIA

The world is facing the largest young generation ever. Youth are using new technologies more and differently than adults. Simply put, young people are online. We often hear about the negative side of this technology: unlimited amounts of data, opportunities and risks; failure of youth to read and/or ignore privacy policies; and lack of authenticity of the source of particular SRHR information. From cyber bullying to sexting, social media opens the door for problems in social relationships and may create an environment for sexual harassment. Yet, while youth being online brings about new challenges and risks when it comes to SRHR, social media also represents a perfect tool to help empower young people to make their own life choices.

Social media has also changed how advocacy and activism is done. The Internet has made it infinitely easier to express our views and share our concerns while we go about our lives. Be it shared petitions, pictures on Facebook walls, tweet-a-thons, blog posts, thematic Pinterest boards or tumblrs and Youtube videos, the Internet is full of online groups of like-minded people where news travels fast and at times large numbers of people can be mobilized with a few clicks. It's not all rosy, though. Even when not contemplating such worrying phenomena as cyberbullying, identity theft and other vulnerabilities that the online world expose us to, the use of social media for reproductive justice and sexual rights activism can be tricky and at times disappointing.

Here - while being honest and pragmatic - we would like to explore some of the opportunities that social media offer to SRHR advocates. There's a brave new world out there full of learning and advocacy opportunities, but don't believe anyone that claims that all you need to change the world is a Twitter account.

Social media as a tool for personal growth

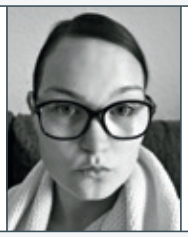
While corporate accounts abound in social media, the basic unit of social media is still the private user that fills the web 2.0 with the realities of his or her everyday life, values and reactions to current affairs. That is where the argument for absolute Internet democracy lies. Once you are recognized as a creator of great content, you may attract a large following without having to be affiliated to anybody or anything or being able to add a fancy job title to your name. In many cases the authenticity of a recognizable and unique voice is appreciated more than a well-established corporate identity. On the other hand organizations that are able to employ community managers, whose sole function is to craft a social media presence, certainly gain in their capacity to dedicate a lot of time to it and react quickly to incoming news.

Nevertheless, it has been the individual, semi-anonymous (depending on the platforms used) user that has gained the most from the Internet revolution. Once you are over the digital divide, a great mass of information reaches you through your device and your dependency on heavy library books and renowned in-person experts is diminished. You get to listen to the people.

Obviously, and exactly as in the before-Internet world, not everybody is worth listening to. Fact checking is almost non-existent though, and many "reblog" and "retweet" buttons are clicked for false statements, exaggerations, misunderstandings and just cute cat pictures. However, once you weed through the jungle of memes, petitions, viral videos and conspiracy theories, you get to hear voices that the conventional media would never let through. If you are wondering about something - let's say finding a visual explaining the difference between gender identity and gender expression, or a list of empowering SRHR-related movies to show to your youth volunteers - rest assured that somebody has already done something similar and is one Google search away.

There are numerous ways to learn online, as many as people. While the opportunity to follow, for example, an Ivy league university course on demography and family planning for free and from your home is revolutionary, even more so is the realization that there are countless SRHR activists out there and that just by reading their updates you expand your knowledge while under the impression of just clicking through your RSS feeds. You still have to filter and critically assess what you read, accepting that most of the people out there are not experts on any of the topics they are commenting on. Their position and interests will never coincide 100% with yours. This is key.

An example of a comprehensive sexuality education campaign.



Luize Ratniece

Velimir Saveski

Social media as advocacy tools in the former Yugoslav Republic of Macedonia (FYR of Macedonia)

It is easy to overlook or underestimate the power of radio in the world of broadcast television and social media. Furthermore, in the FYR of Macedonia, coverage of youth SRHR has often been neglected or limited in traditional media forums. As a response to this, the Health Education and Research Association (HERA) created the "Sexy Hood" radio show with the aim to deeply penetrate and dispell existing SRHR taboos. Created for young people by young people, the radio show was launched on 14th November 2012 and remains an ongoing success story on the online Radio MOF. It has proven to be a very successful and creative way in which social media can be used to promote SRHR.

HERA has also used social media to launch 2 strong campaigns regarding youth SRHR in response to the new abortion bill in the FYR of Macedonia and comprehensive sexuality education (CSE).

A year ago a new abortion law was adopted in Parliament, despite public protest due to restrictive elements of the law. HERA launched a social media campaign regarding the new law in June 2013. A fact sheet named "4 barriers to abortion with the new law" was created. The fact sheet was a simple comparison between the old and the new law and highlighted expected outcomes if the new amendments were to be adopted. It was shared more than 100 times and the information was able to reach a couple of thousand users on social media.

When almost all media can be or are influenced by the government, the only way to address SRHR is via social media. That is why, as strong youth advocates for CSE, the youth group in HERA created a promotional video named "Everyday questions deserve an answer" as support to the ongoing campaign for introducing CSE as part of the educational curricula. During the petition signing process, during the last week of the campaign, the promoted video post was seen by 192 000 people, liked by 200 people and had 20 shares.

A group of people from the Twitter community in the FYR of Macedonia, as part of the annual charity Twitter calendar, decided to address SRHR and CSE by posing nude. HERA's youth team helped participate in the development of the calendar. The calendar was used to help illustrate how stereotypical views and attitudes towards SRHR help promote gender inequality in our community and how introduction of CSE would promote progressive and liberal views and beliefs on gender and SRHR in society.

Another successful way for addressing youth SRHR is the I [heart] Being a Girl blog created by Youth Sexual Awareness for Europe (YSAFE), the youth network of the International Planned Parenthood Federation European Network. It is a platform for collecting testimonies of young women as a way to encourage a positively framed dialogue about gender, sexuality and femininity. Created in 2010, the blog won a World Summit Youth Award in 2012 and continues to explore new ways to empower girls and young women online and offline.

Closing thoughts

The Internet and the round-the-clock updates can be both a major source of frustration and of inspiration. It is important to always view your own cyber-activism (and that of everybody else) critically. Nobody knows how many Facebook "likes" and retweets it will take to change an oppressive law or how many people who indicate online that they are going to the protest you are staging will actually show up in person. Furthermore, there is no shortage of good and bad news or helpful and hateful accounts of reality in social media. If you acknowledge this and expose yourself to just the right amount of each to reach a productive state of hopeful rage, social media has the capacity to keep you motivated in SRHR activism. Then you can share all of that with your friends and brothers and sisters in arms on Facebook.

Luize Ratniece,
Member,
Latvia's Association for
Family Planning and Sexual Health
"Papardes Zieds,"
luize@feels.it,
@_uize

Velimir Saveski,
Board member,
Health Education and Research
Association, FYR of Macedonia,
velimir.saveski@gmail.com,
@Velimir_Saveski

Check out online:
twitter.com/ysafe
twitter.com/HERA_mkd
iheartbeingagirl.blogspot.com
facebook.com/seksi.maalo

Use of media to educate youth on abortion.

STARTING YOUNG: DEVELOPING EGALITARIAN GENDER NORMS AND RELATIONS TO PROMOTE SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) OF ADOLESCENTS AND ADULTS

Twenty years ago, the Cairo International Conference on Population and Development (1994) Programme of Action shifted the paradigm of population control to a rights-based approach to sexual and reproductive health (SRH) and recognized the importance of promoting gender equality as critical to these efforts. Evidence shows that the SRH of adults and adolescents alike are influenced by gender inequalities in the following ways: a) unequal power between women and men and girls and boys in reproductive, sexual and other household decision-making; b) social norms that promote dominant masculinity and female subordination (i.e. unequal and harmful gender norms); c) unequal access to and control over resources by women and girls; and d) laws and policies that perpetuate women's and girls' low status in society (1-3).

The following examples illustrate how gender inequalities shape the SRH of adolescents and adults. In sub-Saharan Africa, girls and young women (age 15-24) are twice as likely to become infected with HIV compared to their male counterparts (4). Their disproportionate vulnerability is driven by early exposure to sex, often coerced, and a pattern of transactional sex with older men with whom they may have less power to negotiate condom use. Globally, adolescent girls experience high rates of early and unwanted pregnancies with consequences ranging from maternal morbidity and mortality to resorting to unsafe abortion and having to drop out of school. Their vulnerability stems from gender norms that force them into marrying early, pressure them into early sexual activity and deny them the knowledge and skills to protect themselves (5). Globally 1 in 3 women have experienced physical and/or sexual violence by an intimate partner. Such violence starts early in the lives of girls with nearly 30% of girls 15-19 years experiencing intimate partner violence (6). Studies show women's attitudes justifying a man beating his wife (a proxy for norms tolerant of violence) are a significant risk factor for women's victimization to intimate partner violence (7). Adolescent boys and young men start sexual activity early and take sexual (e.g. unprotected, multiple sexual partners or paid sex) and other risks (e.g. harmful alcohol and substance use) (8). These behaviours are influenced by peers, older men and other societal messages (e.g. media, sports, religious, military institutions) that validate masculine norms and identities (9). Population-based surveys from 10 countries show that rigid gender attitudes are formed early, with 50-83% of boys (15-19 years old) reporting that it is justifiable for a man to beat his wife under certain circumstances (10).

Based on evidence, there is a growing consensus among many experts that efforts to develop mutually respectful, supportive and egalitarian relationships between women and men need to start early in the lives of adolescents. Hence, they can address behaviours during adolescence (e.g. poor health care seeking among boys, early sexual debut among girls) and shape the trajectory of SRH of adults (11). Gender socialization starts in early childhood when boys and girls are treated differently and given gender specific toys and messages that boys don't cry and girls must behave lady like. In addition, adolescence is a crucial period when both boys and girls go through puberty related changes, explore their sexuality, further develop their gender identities, attitudes and behaviours and may begin to form intimate relationships. As such, it provides a critical opportunity to shape positive and egalitarian attitudes and norms and healthy SRH behaviours before these become rigid and entrenched.

A number of agencies including the United Nations, donors and many community-based and international NGOs have undertaken programmes and interventions to promote gender equality. There is emerging evidence of what works to promote, change and sustain egalitarian gender norms and attitudes and behaviours among adolescents as they transition into adulthood. For example, recognizing the particular vulnerabilities of adolescent girls, there is a growing global effort to implement programmes to empower girls and young women by: keeping them in schools through conditional cash transfer programmes (CCT); building their confidence, skills and assets; or providing them livelihood, life skills education and social and mentoring support. While a small number of these have been rigorously evaluated (e.g. CCT with girls in Malawi and a combined livelihood and life-skills education intervention in Zimbabwe) and shown to have positive impacts on behaviours and SRH outcomes (e.g. decrease in HIV prevalence, unwanted pregnancies) several others are yet to be evaluated (12-14).

In parallel, there are also several programmes being implemented with boys and young men to challenge notions of dominant masculinities, promote egalitarian gender attitudes and norms and improve their SRH behaviours including reducing perpetration of violence against women. Interventions with boys and men include individual or small group school-based and community-based participatory education to build critical reflection on what it means to be a man and challenge gender stereotypes, attitudes and acceptability of violence, as well as, mass media campaigns to raise awareness and challenge masculine norms (e.g. soap operas, lifestyle campaigns) (15-17). Reviews of interventions with men and boys have examined their impact on SRH and HIV behaviours and prevention of sexual violence. There are a small number of rigorously evaluated interventions with a positive impact on men and boys' behaviours and health outcomes and a larger pool of less rigorously evaluated studies showing improvements in attitudes of men towards gender equality, but not behaviours (15-17).

The evidence base on what works to promote empowerment and egalitarian gender attitudes, norms and behaviours among adolescent girls and boys and improve their SRH needs further strengthening. First, programmes need to be evaluated and evaluated with stronger designs where possible (e.g. experimental designs with individual or cluster randomization). Second, outcomes need to

Avni Amin

Venkatraman Chandra-Mouli

go beyond measuring individual attitudes to changes in community level norms and in behaviours. Lastly, evaluations need to consider sustained behaviour changes over time beyond the typical 6 to 12 months post-interventions that most studies have done so far.

There are a couple of important lessons learned for promoting gender equality to achieve SRH. First, there is an emerging consensus that it is no longer enough to work only with girls or only with boys. The literature on gender equality has been polarized by a focus on a women and girls only approach versus an argument for an approach focusing on boys and men (11, 18). Research shows that success is more likely where interventions have worked with both boys and girls and men and women in a synergistic or synchronized manner. While there has been considerable emphasis on challenging dominant masculinities, there is an equally critical need to challenge "passive femininities" or norms that perpetuate female subordination and have devastating impacts on girls' self-esteem, body image and their ability to assert themselves in their relationships. Lastly, challenging harmful gender norms (both masculine and feminine) and unequal power between women and men and boys and girls, requires going beyond efforts at the individual level (i.e. working with girls or boys) to challenging gender inequalities at the structural level. Specifically, this requires implementing strategies with whole communities (e.g. community and religious leaders, parents, family members, peers) and institutions (e.g. schools, sports, media, religious, health, law enforcement, justice, political) to support and sustain widespread societal changes in harmful gender norms and in discriminatory practices in order to create an enabling environment for adolescent SRHR.

Avni Amin, PhD,
Technical Officer,
Dept of Reproductive Health and Research,
WHO headquarters, Geneva
amina@who.int

Venkatraman Chandra-Mouli, MBBS, MSc,
Scientist,
Adolescent Sexual and Reproductive Health,
WHO headquarters, Geneva,
chandramouliv@who.int

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PREVENTING VIOLENCE IN ADOLESCENTS AND YOUNG PEOPLE IN EUROPE: AN UNDERSTATED HEALTH PRIORITY

There is a large burden from interpersonal violence

Interpersonal violence is the fourth leading cause of death in young people aged 15-29 years and accounts for the premature loss of 6900 lives in 2011 in the 53 countries of the WHO European Region (1). Although this is an improvement from 2000 when there were 15 000 homicides, representing a fall of 54%, non-fatal interpersonal violence is very common and has far reaching consequences which affects the physical, mental and social well-being of youth. The *World Report on Violence and Health* defines interpersonal violence as the intentional use of physical force or power, threatened or actual, against another person that results either in injury, death, psychological harm, maldevelopment or deprivation (2). It may be directed against children, partners, elders, acquaintances or strangers. Homicides are just the tip of the iceberg and it is estimated that for every murder there are at least 30 who warrant emergency medical attention either in emergency departments or requiring hospital admission, affecting nearly half a million young people each year, resulting in high health costs. Youth violence is one of the less studied types of violence and there are few community surveys and systematic studies that help us understand the true scale of the problem, the risk factors, consequences, costs and what can be done for prevention (2, 3).

A major cause of inequality

Although all types of interpersonal violence happen in all societies, their occurrence is far from random. Interpersonal violence is very unequally distributed in the Region and eight of 10 homicides occur in boys and young men and almost 9 out of 10 occur in the low- and middle-income countries of the Region (1). The mortality rate in low- and middle-income countries is 6.03 deaths per 100 000 population which is 5.9 times higher than that in high-income countries of 1.02 per 100 000 population. There has been improvement in this death rate ratio since 2000 when it was 8.9, suggesting that some convergence is occurring for interpersonal violence (1). Figure 1 shows mortality rates over time and demonstrates that convergence has occurred between the Commonwealth of Independent States (CIS)* and the European Union (EU) (4). It also shows peaks in mortality with widened inequalities in 1996 and 2002 during periods of economic, political and social transition, suggesting that much violence is strongly linked to socioeconomic determinants.

When individual countries are compared there is a 40-fold difference between the country with the highest youth homicide rate (Russian Federation with a rate of 10.59 per 100 000) compared to that with the lowest (Slovenia at 0.26 per 100 000) (4). Eighty per cent of the 527 000 disability adjusted life years (DALYs) lost from interpersonal violence (a composite measure of years of life lost due to premature death and years lived with disability) in this age band were in males (420 000 DALYs) as opposed to females (108 000 DALYs) (1). Males are at many times greater risk of being involved – as victims and as perpetrators in both fatal and non-fatal violence. In male homicides the perpetrator is male in 90% of the cases (3). Females are at substantially higher risk than males of being victims of sexual violence and of serious physical assault in intimate partner violence. It is estimated that 38% of female homicides are due to partner violence (5). Homicide rates are strongly correlated with economic inequality, the highest rates occurring in the poorest communities of societies with the biggest gaps between the rich and the poor, as demonstrated both between countries and within. Within countries fatal and non-fatal assault rates in adolescents and youth are several times higher in more socio-economically deprived groups compared to the more affluent (3). There is compelling evidence that interpersonal violence is partly driven by socioeconomic determinants and that it is a leading cause of inequity and social injustice (2, 3). Across Europe, violence results in large expenditures not only for health care and social and economic development and support foregone, but also for other sectors, such as law enforcement and compensating survivors for their suffering. It diverts many billions of Euros from more constructive investments. The fear of such violence provokes personal and societal reactions that further widen the gaps between the rich and the poor. There are enormous indirect costs, too, with large societal losses that can result in slower economic development, socio-economic inequality and an erosion of human and social capital (2, 3).

What are the risk factors?

Numerous biological, social, cultural, economic and environmental factors interact to increase young people's risk of being involved in violence (2, 3, 6). These include: being a victim of child maltreatment and suffering adverse experiences in childhood; male gender; weak legislation to protect against violence; norms that support violence; gender inequalities; exposure to violence; fear of violence in schools and the community; associating with violent or delinquent peers; using alcohol and drugs; availability of weapons; familial strife; community disorganization; low neighbourhood resources; low social capital; income and social inequality; and other types of interpersonal violence. Investing in protective factors can prevent violence from developing among young people. These include: good social skills; self-esteem; academic achievement; strong bonds with parents; positive peer groups; good attachment to school; community involvement; and access to social support.

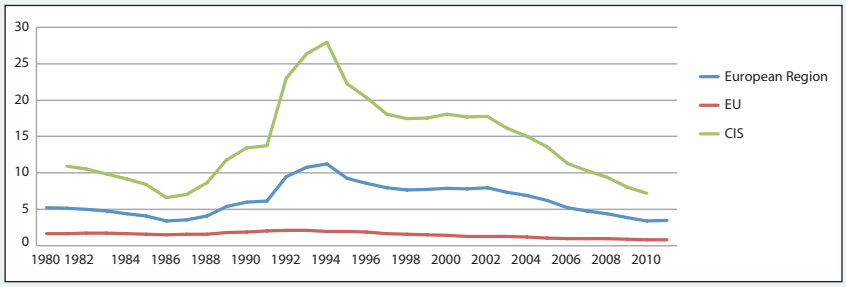
What can be done about violence among young people?

The mass media and society are quick to demonize violent young people, but youth is a period of vulnerability and the root causes of violence, such as abuse and neglect suffered in childhood, need to be considered. Childhood and adolescence are periods of developmental changes, and exposure to adversity may result in atypical development and be associ-

Dinesh Sethi

Francesco Mitis

Figure 1. Homicide rates per 100 000 population in young people aged 15-29 years for the WHO European Region, CIS and the EU (4).



ated with violent and health-damaging behaviour (2, 3, 6). Preventing such adversity and implementing comprehensive intervention programmes in adolescence and early adulthood can help to integrate young people into the mainstream.

Overall, good evidence indicates that violence among young people can be prevented through the organized efforts of society. There is also an increasing awareness of the intergenerational transmission of violence and how prevention efforts need to start early in childhood and be based on a life-course approach (2, 3, 6). Prevention programmes cut across the activity areas of many sectors and require multiagency and multidisciplinary work. The evidence base is much stronger for interventions that adopt a public health, rather than criminal justice, approach and for those that reduce risk factors and strengthen protective factors among young people early in life than for measures that seek to reduce violent behaviour once it has already emerged. Such primary prevention approaches include: parenting programmes; preschool enrichment; social development programmes; academic enrichment programmes; reducing access to alcohol; dating and relationships programmes; and social norms approaches. Selected effective interventions that seek to prevent violence directly by making environments safe include: stricter legislation for weapon carrying; use of safer drinking vessels; bullying prevention programmes in schools; managing nightlife environments; urban design strategies; and social marketing programmes. Tertiary prevention approaches aim to reduce violence or limit its effects once it has occurred and include: problem-oriented policing; multi-systemic therapy; behaviour change counselling; gang intervention/prevention programmes; and gender and age appropriate services for victims of violence (2, 3, 6).

Way forward

International policy initiatives such as the World Health Assembly Resolutions on Violence Prevention and the UN Convention of the Rights of the Child have been catalysts for policy action. To ensure wider implementation also requires an explicit recognition by policy-makers that violence is a preventable public health problem (2, 3, 6, 7). Resources need to be mobilized in order to build capacity and implement and evaluate interventions on a broader scale across all sectors. Policies which safeguard children, youth, women and elders from violence need to be integrated and prioritized across the broad range of social policy (education, health, social welfare, economic and law enforcement policies) and require a coordinated multisectoral response (7). One of the challenges facing society is mobilizing the political support needed to tackle the current norms of violence, poverty and alcohol consumption which perpetuate interpersonal violence in all its pervasive forms (3). The new European health policy, *Health 2020* urges all the sectors to work together to improve health. It emphasizes the life course approach to achieve better equity in health through evidence informed prevention. Violence prevention programmes underpin these crucial principles.

Dinesh Sethi, MSc, MD, FFPH,
Technical Officer,
Violence and Injury Prevention Programme,
WHO Regional Office for Europe,
Copenhagen,
din@euro.who.int

Mr Francesco Mitis,
Technical Officer,
Violence and Injury Prevention Programme,
WHO Regional Office for Europe,
Copenhagen,
mit@euro.who.int

*CIS countries: Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, Republic of Moldova, Russian Federation, Tajikistan, Turkmenistan, Ukraine, Uzbekistan.

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A LOOK FROM UKRAINE: DONOR INVESTMENT CAN HELP RESOLVE YOUTH REPRODUCTIVE HEALTH PROBLEMS

In 2006 when the government of Ukraine adopted the State Programme *"Reproductive Health of the Nation until 2015"*, family planning finally became a more important item on Ukraine's health care system agenda.

In the last eight years, the country has made marked progress in improving family planning practices and procedures, including the provision of free contraceptives when needed. Various state entities (for example, the Ministry of Health, regional health administrations, state social services, regional departments of education), private sector companies and the U.S. Agency for International Development (USAID) have launched intensive efforts to improve the reproductive health of Ukrainian adolescents, yielding tangible results. Today many more young people and young couples visit regional family planning centres and city consultation centres for women. For example, the Regional Family Planning Centre in Sumy has reported that the number of their family planning clients aged 18-25 has increased by 8 per cent each year for the past 3 years.

A Multi-Indicator Cluster Survey conducted by UNICEF in 2012 and supported by USAID showed a decrease in the unmet demand for contraception from 10 per cent in 2007 to 4.9 per cent in 2012. Furthermore, it also showed an increase in the modern contraceptive prevalence rate (CPR) for all women from 38.3% in 2007 to 39.9% in 2012 (1, 2). The CPR in Ukraine continues to be one of the highest in the Region: in Armenia the CPR for all women was 16.9% in 2010 and in Kyrgyzstan the CPR for all women was 22.7% in 2012 (3, 4). Although a small increase, it is a positive signal that Ukrainian women, including young women, are increasingly using modern methods of contraception. Most importantly, the Ministry of Health of Ukraine has reported that data on pregnancies and abortion rates among teenage girls has improved. The graph below demonstrates the descending trend for abortions for 15-17 year old girls over the last five years (see Figure 1).

Raising Awareness

USAID has been a leading supporter in the effort to raise awareness of the importance of family planning and women's health, focusing on deceasing abortion rates and teenage pregnancies in Ukraine. In 2012 USAID launched a national family planning communication strategy to encourage young adults to take responsibility in romantic partnerships, plan families and properly space the birth of their children. The messages targeted at 18-20 year olds included: "Plan your future," "Planned children in a planned time," "Contraception is better than abortion," and "Family planning is a modern trend." The effort utilized various communications platforms to disseminate its messages, including the social network Vkontakte (http://vk.com/miy_plan_a), a website (http://www.planA.org.ua), a national hotline, mass media and street events. USAID also developed a public service announcement (PSA) entitled "The future is worth planning," which included a 30-second story on how young families plan and space the birth of their children. The Government of Ukraine saw the benefit of the PSA and will broadcast it on Ukrainian TV over the course of the next year.

The USAID supported national communication strategy also called for short interactive educational sessions with youth. Instructors trained by USAID have taught young people about vital family planning issues that are not normally part of secondary school or college curriculums. University students, teenagers at orphanages and young workers have learned about sexuality, ways to protect their reproductive health and modern family planning methods. One teenager at an orphanage in Kharkiv Oblast was so excited about the training that he commented: "I so appreciate this important training. It will help me to start my adult life with more confidence and will guide me on how to protect my health after I leave here."

Bayer Schering Pharma (BSP) was impressed with the effectiveness of the USAID communication training instructors and decided to utilize them for their corporate social responsibility initiative. BSP is now paying instructor fees and covering training expenses in 15 oblasts of Ukraine.

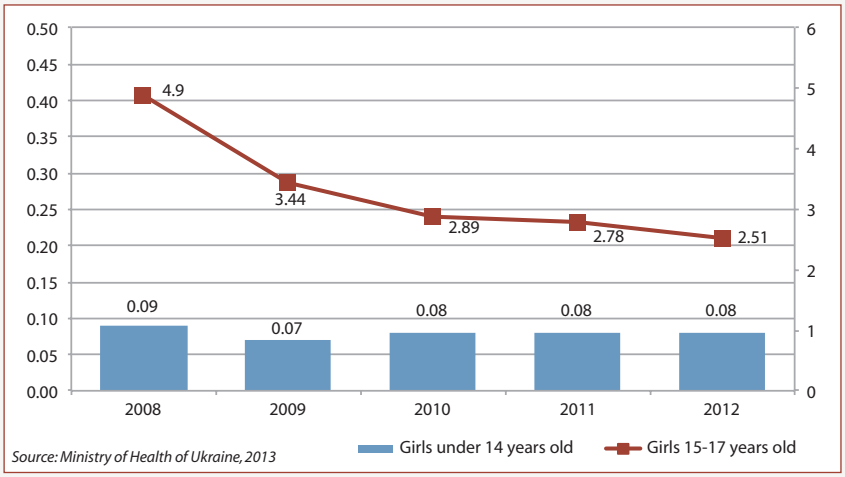
Street events that focus on family planning are a popular communication tool of the national strategy for disseminating family planning messages. These events

Family planning instructors at a street event.

Tatiana Rastrigina

Natalia Karbowska

Figure 1. Trends in abortions rates among girls under 14 years old and girls 15-17 years old in Ukraine, 2008–2012 (per 1000 population of relevant age and sex)



Source: Ministry of Health of Ukraine, 2013

were usually organized during holidays (such as World Contraception Day, Mother's Day, Students' Day, St. Valentine's Day and individual City Days) and used popular contemporary formats – flash mobs, quests, interactive games, contests – combined with concerts in city squares to raise awareness of healthy life styles for young people. The events generated a lot of interest because they were led by young volunteers who talked to their peers and encouraged them to start caring about their own reproductive health. Alina, a 17 year old participant in Ternopil, Ukraine, said she had not seen anything similar on TV or radio that would provide the same type of information. She especially appreciated the opportunity to speak with a gynaecologist at a mobile counselling point.

No story on raising the awareness of young people about family planning in Ukraine would be complete without mention of the cooperation among non-governmental organizations (NGOs). In most cases these youth-run or women-run organizations, generally implementing women's rights and public health projects, were very active partners in the work with youth on family planning. Theatre performances, roundtables with local government and thematic parties were but a few of the types of events that they organized.

These NGOs were also the driving force and key resources for annual family planning weeks, usually organized in May to support the Ministry of Health in its awareness raising work. NGOs knew best how to get the word out within communities about family planning week, resulting in the participation of millions of urban and rural residents across Ukraine. Over 50 per cent of participants were young people and many were exposed to family planning information for the first time. Overall, about 1.4 million youth in 25 regions of Ukraine participated in family planning events and short trainings held in 2006-2013 (5, 6).

USAID has also supported widespread distribution of family planning information and education materials. A brochure "Modern methods of contraception" for the general population, a collection of family planning messages called "Protect your love" and a smaller brochure appropriate for younger teens, entitled "For lovers," which emphasized family planning methods, including abstinence, were regularly disseminated by young volunteers and NGO leaders wherever young people tend to gather - disco clubs, schools, universities, cafes, youth-friendly clinics and during street events. An elderly lady who said she was taking a "For Lovers" brochure for her granddaughter notably remarked: "I was not able to get this information when I was young, so I would like my granddaughter to become more educated than me."

Tatiana Rastrigina,
Senior Project Management Specialist,
Health Office,
USAID, Ukraine,
trastrigina@usaid.gov

Natalia Karbowska,
Deputy Chief of Party for Communications and Capacity Building,
"Healthy Women of Ukraine" Programme,
nkarbowska@fprh-jsi.org.ua

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YOUTH FRIENDLY CLINICS (YFC) IN KYRGYZSTAN: THREE DIFFERENT PERSPECTIVES

Background

Meeting with a medical doctor ... a gynaecologist ... what brings adolescents into a doctor's office? What events in their lives are motivating them to seek health care? Do the adults know how important this visit is for an adolescent boy or girl and/or how much excitement and/or fear they may be experiencing at that moment? Do the medical service providers understand what impact their interaction may have on the future actions and behaviours of their young clients? To what extent is the health care system responsible in ensuring that youth friendly services (YFS) are available and able to address sexual and reproductive health (SRH) for young people?

The "Reproductive Health Alliance Kyrgyzstan" (RHAK) firmly believes that in order to appropriately implement actions aimed at addressing the problems and needs of young people, including those related to sexual and reproductive health and rights (SRHR), the voices of youth must be considered and listened to. This is the basic principle at the heart of youth friendly health services – a principle that is relevant and fundamental to the interaction of all components of the health-care system.

The first efforts to introduce and integrate YFS in Kyrgyzstan were made by RHAK in 2006. At that time a gynaecologist, a psychologist and a lawyer were made available at the facilities of RHAK branches for adolescents to meet with. Within the Salin + project "You are Not Alone", RHAK was also able to establish comprehensive SRHR services in the cities of Karakol and Bishkek. In 2012, with assistance from BMZ (The Federal Ministry of Economic Cooperation and Development of Germany), another 8 YFC were established in both state and non-state clinics in 5 regions of the country. Since then more than 100 medical providers were trained on the provision of SRH services and counselling of adolescents and young people and more than 20 000 young boys and girls of Kyrgyzstan have attended these centres for services. The success of these clinics is explored below through the words of three different individuals involved in their functioning: a member of RHAK, a service provider and an adolescent user.

"Young people visit our clinic to receive a variety of SRH services, including abortion services. In most cases these are clients from vulnerable groups: youth from rural areas, low-income families, children without parental care, sex workers, etc. We often witness how lack of knowledge and information about SRHR inhibits or impedes adolescents, particularly girls, from seeking appropriate and timely care. Furthermore we learned early that we also needed to provide more than medical care. Social support services and legal services were also often required in order to ensure the rights and safety of many of our clients, many whom had been victims of violence. Thus, through our work with youth, we understood the necessity of providing complex, integrated SRHR services such as psychological support, legal assistance and social support. It was necessary to find partners who would work with youth and provide non-medical services and social support. Inability to provide this type of care meant that we would not be able to achieve the sustained positive impact we wished to have on SRHR of adolescents.

We also recognized the importance of ensuring capacity building to train medical service providers in YFS. It is important to strengthen the skills of medical service providers to provide YFS and to improve the knowledge of SRHR among young people through the integration of these topics into the educational system and establishment of YFS at the level of legal, psychological and social services. Only the interaction of all parties will help us to improve the SRH among the youth."

- Gulumkan Kasmalieva, Clinical Chief, RHAK's Clinic of Family Planning and Safe Abortion in Karakol, Kyrgyzstan

"In our centre, we identified the youth as a distinct group of clients for whom adolescent gynaecologists, urologists, psychologists and psychotherapists provide services. A separate laboratory was allocated for young clients (aged 10-21) where laboratory tests and diagnostics are provided free of charge. Within the YFS project in cooperation with RHAK, we established a youth-friendly clinic (YFC), at our location where we provide comprehensive services for young people: provision of medications, condoms and contraceptives and consultation with gynaecologists, urologists and counsellors. Nowadays young people come to the YFC for a variety issues. They are not shy and they no longer fear judgmental treatment from providers. They also come without adults, make their own decisions about visiting the doctor who provides counselling and they jointly solve problems with the provider. If I as a provider am unable to address the SRHR needs of the adolescent myself, I appeal to RHAK to help me find qualified specialists who I can refer adolescents to for adequate services.

Nowadays adolescents come with their own problems and they are more open in their communication with a doctor. Youth have started to trust doctors more: over the last few years, the number of adolescents who have visited the YFC increased by 40%. Information about the YFC and services provided to the youth are distributed by "word of mouth", i.e. from one adolescent to another.

The YFS principle is distinct from the work of doctors in state clinics and it allows me to spend more time with adolescents to provide counselling. I work not only as a gynaecologist at the YFC, but also as a counsellor: all the things we were trained on – to exercise tolerant attitude and attitude of trust, confidentiality, sensitivity to the problems of an adolescent – all this is used in our work. Earlier, while working at a regular state clinic we, doctors, worked based on the principle "came, worked and walked away", while now we try to spend more time with the client, as very often adolescents need just participation and understanding.

As service providers of YFS, we are faced with significant problems. One of the biggest problems is the low awareness among youth and adolescents about SRH and the nature of the existing education system that restricts access to this type of information. In the current service delivery system, it is difficult to integrate a gynaecologist, a urologist, a counsellor and a psychologist in one location. Being able to do so would allow adolescents to receive comprehensive medical care in one place, which would enhance the coverage with integrated services through a 'one-stop-shop'.

I can confidently say that YFC are very necessary in the country and it is necessary to undertake more joint efforts to promote them. As a specialist of YFC, I feel that the government should pay more attention to youth issues and YFCs should be established in every settlement. The state should earmark funds in the budget for this and attract international assistance for the establishment and support of YFCs, equipping them with equipment and medicine and develop a system for medical specialists based on the principles of YFS."

- Lola Davletova, gynaecologist at the YFC at the Family Medicine Centre #2, Bishkek, Kyrgyzstan

"I remember my first visit to the YFC of RHAK. There was a fear that in the course of the first visit I will be asked to sit in the gynaecological chair. Before that I visited a gynaecologist only twice at a regular state hospital and I did not like it. During my visit at the gynaecologist in a state clinic there were other doctors coming in and out and talking about something. My doctor-gynaecologist had to ask me several times why I was there because she was talking with her colleagues. I did not like it. Then my classmate told me about clinics providing YFS. She said that there was a rule of confidentiality at that clinic and the doctors had been specially trained to communicate with adolescents. My classmate gave me the address and telephone number of this clinic. I made an appointment and came to the YFC. The very first thing that caught my eye was comfort. It was so cozy in the lobby and a very friendly receptionist of the clinic led me to the doctor's office. The receptionist told me that the clinic receives clients only based on an appointment, so people would not have unwanted meetings and would not intersect. After I came into the office, I saw a woman young enough and very welcoming. Nobody asked me to sit down on the gynaecological chair; no one was rude with me. People were friendly and listened attentively. I had a very friendly conversation, I learned a lot, and I did not have to get onto the gynaecological chair that I feared so much. Now I am a regular customer of the YFC and I advise my girlfriends and friends to go only there!"

- Samara, 17 years old

Correspondence to Gulmira Suranaeva at: suranaevag@mail.ru

Youth promoting youth friendly services at the RHAK clinics.

THE TEENAGE PREGNANCY STRATEGY FOR ENGLAND: CONCERTED EFFORT CAN MAKE A DIFFERENCE!

Introduction

Last year, in a British public opinion poll, teenage pregnancy rates were estimated to be 25 times higher than official government statistics. In fact, rates are the lowest level since 1969 when data collection began (1). As a result of the previous Labour Government's Teenage Pregnancy Strategy (2) and the concerted efforts of local government, health partners and individual practitioners, between 1998-2012, the under-18 conception rate fell by 41% (1).

The Teenage Pregnancy Strategy for England was published in 1999. The ten-year Strategy was the first comprehensive approach by Government to reducing England's historically high teenage pregnancy rates, which had shown no sustained downward trend, and to improving the disproportionately poor outcomes for young parents and their children. Based on the international evidence of what works, the Strategy set out a 30 point action plan on four themes: joined up action at national and local level; better prevention – improving comprehensive sex and relationships education (SRE) and access to contraception; a national communications campaign to reach young people and parents; and coordinated support for young parents. The headline target was to halve the under-18 conception rate from 1998 to 2010.

The first phase of implementation: 1999-2005

A Teenage Pregnancy Unit (TPU) was established to oversee implementation of the Strategy, with support from a cross-departmental Board and an Independent Advisory Group of external experts. Regional Teenage Pregnancy Coordinators (RTPC) were appointed in the nine Government Office regions and every local government area appointed a Teenage Pregnancy Coordinator (TPC) and Teenage Pregnancy Partnership Board with representation from health, education, social services, youth services, housing and relevant NGOs. A national group of NGOs was also established to harness additional expertise. The aims and target of the strategy were embedded in a wide range of Government programmes to maintain the priority and strengthen joint working between agencies.

Local under-18 conception rate reduction targets were agreed with each area. Attainment of all local targets would achieve the national reduction target of 50%. An annual local implementation grant was provided to each area, on average 300-400 000 pounds. The grant was intended to supplement, not replace, mainstream funding with conditions on spending mandating the appointment of the TPC and Partnership Board and providing an annual report on local progress.

Every local partnership board developed a local Teenage Pregnancy Strategy, informed by guidance issued by the TPU. Each strategy was assessed by the RTPCs who facilitated regular network meetings and provided expert support to local areas.

To support local implementation of the Strategy, the Government issued SRE guidance to schools and a range of guidance on improving uptake of early contraception and sexual health advice (2). This included guidance on young people friendly contraceptive services which later developed into *You're Welcome*, the Department of Health quality criteria for youth friendly health services, endorsed by WHO in 2009. Local areas also received funding for teachers and school nurses to participate in a national professional development programme to improve the quality of SRE.

A national media campaign, aimed at 13-17 year olds, promoted messages on resisting peer pressure, accessing early advice and using condoms and contraception to prevent pregnancy and sexually transmitted infections (STIs). A separate campaign encouraged parents to talk to their children about sex and relationships.

Mid-strategy review: 2005-2007

In 2005 the latest data showed the under-18 conception rate had declined by 11% but there was wide variation in local progress. If all local areas had achieved the reductions of the best 25%, the national reduction would have been 23%. This prompted a 'deep dive' review of six areas, led by the TPU and the Prime Minister Delivery Unit (3). Three areas with declining rates were compared with three areas of similar levels of deprivation, where rates were static or increasing. The findings were clear. Areas with better reductions were implementing all aspects of the Strategy and involving all agencies to create a 'whole systems' approach, with strong senior leadership. The review was a significant milestone in the Strategy. It challenged the common acceptance of high teenage pregnancy rates and demonstrated that if young people were given choices, rates could be reduced, even in deprived areas.

Drawing on the review, the Government issued new more prescriptive guidance for local areas, setting out the ten key factors for an effective local strategy, together with detailed local data analysis and information to strengthen targeted work with young people most at risk. A self-assessment toolkit was provided to help areas identify and address gaps in their local plans and strengthen local performance management. To accelerate reductions in the areas with high and increasing rates, Ministers requested six monthly progress reports from local senior leaders and additional support was provided to the areas by the RTPCs.

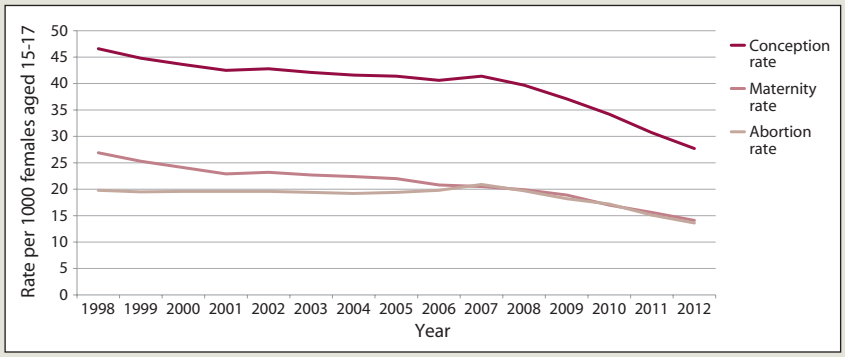
The traction of the new guidance and Ministerial focus was strengthened by new legislation (Children Act 2004) which put a duty on local authorities to cooperate with partner agencies and promote a more joined up and holistic approach to improving the health, education and wellbeing of children and young people (Every Child Matters 2004). The reach of the Strategy was also increased through other government programmes to integrate health promotion and drop in services in schools and initiatives to provide more intensive support for vulnerable young people.

2008-2011: a strengthened focus on contraception

By 2008 the under-18 conception rate was continuing to decline, but conceptions leading to birth were declining faster

Alison Hadley

Figure 1. Conception, maternity and abortion rates per 1000 females aged 15-17 (1).



than conceptions leading to abortion, indicating the need for a stronger focus on increasing early access to effective contraception. This was highlighted by new evidence on the importance of improved contraceptive use in reducing teenage pregnancy rates (4). Additional government investment was secured to improve knowledge and access to the full range of contraception, particularly the newer long acting reversible contraception (LARC) methods. Funds were distributed regionally with a focus on activities, such as training on LARC fitting, which would be sustainable beyond the three-year lifetime of the fund.

To help improve awareness and uptake of contraception, a new national campaign was launched – *Sex. Worth Talking About.* The campaign was informed by a marketing review that showed the greatest impact of national communications would be to promote and model a more open culture around sexual health advice. The ads showed everyday conversations about contraception and chlamydia between young people, with parents and with professionals on radio, cinema and prime time TV to reach and be overheard by the widest audience. The notable lack of complaints indicated a growing public acceptance of the importance of good sexual health information for young people.

Progress to date: 1998-2012

The latest annual data for 2012, published in February 2014, show a 41% reduction in the under-18 conception rate from 1998 to the lowest rate for more than 40 years; all local areas are now showing reductions, including those with previously slow progress; and maternity and abortion rates are now both declining (1). Interestingly, as Figure 1 illustrates, the reduction in the conception rate has accelerated significantly since 2008. As teenage pregnancy is a complex issue requiring a multi-faceted approach, it is unlikely that one factor has driven the more recent decline. More probable is a combination of factors: the cumulative impact of improved prevention work through service improvements, workforce training and wider Government initiatives; increased choice of LARC methods; and the benefits of time in changing the culture that if young people are given choices, high rates are not inevitable.

Yet despite the significant progress, there is much more to do! England's under-18 conception rate remains higher than comparable western European countries and progress between local areas continues to vary significantly. If all local areas had achieved the reductions of the best 25%, the national reduction would be 52%. High quality SRE and easy access to contraception are not yet available to all young people and young people continue to report stigma and embarrassment as key barriers to visiting contraceptive services early.

Key elements of success

It is difficult to distill the many lessons we learned from implementing the Teenage Pregnancy Strategy, but six elements stand out. These are important for England as we try and maintain and accelerate progress. They may also be transferable to other countries. Having national and local targets helped maintain a focus; consistent promotion of the evidence by government helped keep the strategy on track; translating the evidence into guidance with clear actions for different agencies, helped local areas achieve the necessary 'whole systems' approach; good data and local intelligence from service providers were essential for monitoring and improving performance; a hub and spoke structure, involving national, regional and local partnerships was important in identifying barriers and supporting implementation; and finally, senior leadership at national and local level was vital for maintaining the priority, raising awareness of why teenage pregnancy matters, challenging the acceptance of high rates and championing young people's rights to informed choices.

Perhaps one of the most important lessons for England is that high teenage pregnancy rates are not inevitable and that concerted effort, evidence based approaches and sufficient time can bring about change. Now we have to make sure public opinion catches up with our progress!

Alison Hadley, OBE,
Director, Teenage Pregnancy Knowledge Exchange,
University of Bedfordshire, England,
Alison.hadley@beds.ac.uk

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4. Santelli J et al. Explaining recent declines in adolescent pregnancy in the United States: the contribution of abstinence and improved contraceptive use. *Am J Public Health 2007*;97(1):150-156.

RESOURCES

Health for the World's Adolescents. A second chance for the second decade, WHO, 2014.

This new dynamic, multimedia, online report offers a state-of-the-art overview of why adolescents need specific attention, distinct from children and adults. While the summary is available in pdf format all other information is entirely web-based. Available at:
http://apps.who.int/adolescent/second-decade/

Adolescent HIV testing, counselling and care. Implementation guidance for health providers and planners, WHO, 2014.

This web based interactive tool utilizes multi-format resources to help providers and programmers provide more adolescent appropriate and effective HIV services. Available in English at:
http://www.who.int/maternal_child_adolescent/documents/hiv-testing-counselling/en/

HIV and adolescents: Guidance for HIV testing and counselling and care for adolescents living with HIV, WHO, 2013.

This guidance document provide specific recommendations and expert suggestions on prioritizing, planning and providing HIV testing, counselling, treatment and care services for adolescents and can be used with the online tool above. Available in English at:
http://www.who.int/hiv/pub/guidelines/adolescents/en/

Brief on Engaging Men, Changing Gender Norms Directions for Gender-Transformative Action, UNFPA and Men Engage, 2014.

This advocacy brief highlights the underlying principles for work with and successful engagement of men and boys to transform gender norms. Available in English at:
http://www.unfpa.org/public/home/publications/pid/16168

Adolescent Pregnancy. A Review of the Evidence, UNFPA, 2013.

An update on the current situation of adolescent pregnancy, this report covers trends over the last ten years and reviews challenges, successes and proven interventions. Available in English at:
http://www.unfpa.org/public/home/publications/pid/15772

Adolescent job aid. A handy desk reference tool for primary level health workers, WHO, 2010.

For use in conjunction with Orientation Programme on Adolescent Health, the desk reference helps health workers respond more effectively and sensitively to their adolescent clients. Available in English, Albanian, Chinese and French at:
http://www.who.int/maternal_child_adolescent/documents/9789241599962/en/

Generating demand and community support for sexual and reproductive health services for young people. A review of the literature and programmes, WHO, 2009.

This global review of evidence looked at 30 studies to help identify evidence based interventions to help create demand for SRH, as well as, community acceptance. Available in English at:
http://www.who.int/maternal_child_adolescent/documents/9789241598484/en/

Engaging Men and Boys: A Brief Summary of UNFPA Experience and Lessons Learned, UNFPA, 2013.

This report illustrates a range of initiatives that have engaged men and boys for the promotion of gender equality as well as SRH and rights. Available in English at:
http://www.unfpa.org/public/home/publications/pid/13532

Lisa Avery

Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings. An In-depth Look at Family Planning Services, Women's Refugee Commission, Save the Children, UNHCR, UNFPA, 2012.

This report documents good practices and provides recommendations to improve access to quality SRH services for adolescents in humanitarian settings. Available in English, Spanish, Arabic and French at:
http://www.unfpa.org/public/home/publications/pid/14407

SAFE II publications: Increasing the knowledge base on young people's sexual and reproductive health and rights in Europe, IPPFEN, 2014.

The summary report and country factsheets share key findings from qualitative research in 5 countries during 2009-2012. Available in English at:
http://www.ippfen.org/resources/safe-ii-publications-increasing-knowledge-base-young-people's-sexual-and-reproductive-heal

Youth-friendly health policies and services in the European Region, NHS Scotland and WHO Regional Office for Europe, 2010.

Using a series of case studies, this publication shares how health systems in Member States of the WHO European Region respond to meeting the health and developmental needs of young people. Available in English at:
http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2010/youth-friendly-health-policies-and-services-in-the-european-region2

Social determinants of health and well-being among young people. Health Behaviour in School-aged Children (HBSC) study: international report from the 2009/2010 survey. WHO Regional Office for Europe, 2012.

This latest addition to the HBSC series was highly commended in the 2013 BMA Medical Book Awards competition, health and social care category. It supplies much needed up-to-date information on adolescent health, including SRH in 43 countries and regions in the WHO European Region and North America. Available in English and Russian at:
http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications

"Young people's health as a whole-of-society response" series, WHO Regional Office for Europe, 2011.

This series outlines how gender differences and inequalities affect various aspects of illness, health and wellbeing in girls and boys in the European Region, including SRH.
http://www.euro.who.int/en/health-topics/Life-stages/child-and-adolescent-health/publications/2012/young-peoples-health-as-a-whole-of-society-response-series

Upcoming Events

The International Centre for Reproductive Health (ICRH). ***Sexual and reproductive health and rights today and tomorrow - ICRH celebrates 20 years of SRHR research, training and advocacy.*** **Dec 4-5, 2014, Ghent, Belgium**
www.icrhb.org and icrhconference2014@ugent.be

Society for Adolescent Health and Medicine. ***Embracing Transitions: Promoting Health Throughout Adolescence and Young Adulthood.*** **March 18-21, 2015 Millennium Biltmore Hotel, Los Angeles, CA.**
www.adolescenthealth.org

Healthy Teen Network's Conference. ***Synergy: Achieving More Together.*** **October 21-24, 2014, Austin, TX**
http://www.healthyteennetwork.org

Royal College of Obstetricians and Gynaecologists. ***13th European Congress of Paediatric and Adolescent Gynaecology.*** **Sept 17-20, 2014, London, England**
www.rcog.org.uk/events/13th-european-congress-paediatric-and-adolescent-gynaecology

European Pubic Health Conference. **Nov 19-22, 2014, Glasgow, Scotland**
http://www.eupha.org

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WHO Regional Office for Europe

Division of Noncommunicable Diseases

and Life-Course

Sexual and Reproductive

Health Programme

UN City

Marmorvej 51

DK-2100 Copenhagen Ø

Denmark

Tel.: +45 45 33 70 00

Fax: +45 45 33 70 01

www.euro.who.int/entrenous

Entre Nous