

# YOUTH FRIENDLY HEALTH SERVICES IN EUROPE



# Entre Nous

THE EUROPEAN MAGAZINE FOR SEXUAL AND REPRODUCTIVE HEALTH

No. 58 - 2004



**Entre Nous is published by:**

Reproductive Health and Research Programme  
WHO Regional Office for Europe  
Scherfigsvej 8  
DK-2100 Copenhagen Ø  
Denmark  
Tel: (+45) 3917 1341  
Fax: (+45) 3917 1850  
E-mail: entrenous@who.dk  
www.euro.who.int/entrenous

**Chief editor**

Dr Gunta Lazdane

**Editor**

Jeffrey V. Lazarus

**Editorial assistant**

Dominique Gundelach

**Layout**

To om bord, Denmark. www.toombord.dk

**Print**

Central tryk Hobro a/s

*Entre Nous* is funded by the United Nations Population Fund (UNFPA), New York, with the assistance of the World Health Organization Regional Office for Europe, Copenhagen, Denmark.

It is published three times a year. Present distribution figures stand at: 3,000 English, 2,000 Spanish, 2,000 Portuguese, 1,000 Bulgarian, 1,000 Russian and 500 Hungarian.

**Entre Nous is produced in:**

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

**Hungarian** by the Department of Obstetrics and Gynaecology, University Medical School of Debrecen, PO Box 37, Debrecen, Hungary;

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

**Russian** by the WHO Information Centre for Health for the Central Asian Republics;

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

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

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

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

For information on WHO-supported activities and WHO documents, please contact the Family and Community Health unit at the address given above.  
Please order WHO publications directly from the WHO sales agent in each country or from Marketing and Dissemination, WHO, CH-1211, Geneva 27, Switzerland

ISSN: 1014-8485

# CONTENTS

**Editorial**

*By Gunta Lazdane and Jeffrey V. Lazarus* **3**

**Sensitisation of mayors in Lithuania to the concept of youth friendly services**

*By Hilary Homans and Agne Bajoriniene* **4**

**A decade of youth clinics in Estonia**

*By Kaie Toomet, Kai Part and Kai Haldre* **5**

**A worrisome situation!**

**Sexual and reproductive health services in the Netherlands**  
*By Anke van Dam* **6**

**Preventing and combating HIV in Russia, Phase I**

*By Olga de Haan* **7**

**Assessing youth-friendly health services in the Russian Federation**

*By Tatiana Kozhukhovskaya, Paul Bloem and Karina Vartanova* **8**

**Young decision-makers of Europe take up the ICPD**

*By Isabelle Sannestadt and Victor Bernhardt* **12**

**Adolescents' reproductive health care**

*By Rebecca J. Cook and Bernard M. Dickens* **13**

**Youth friendly services, addressing diversity and vulnerability**

*By Upeka de Silva* **16**

**Sex does not have to be dangerous to your health**

*By Paul Van Look and Rebecca Harding* **18**

**Sexual health in young people – findings from the HBSC study**

*By Jim Ross, Emmanuelle Godeau and Sonia Dias* **20**

**Youth-friendly health services: Why do young people need special services?**

*Elina Juntunen* **24**

**The need for youth friendly health services in south-east Europe**

*By Jeffrey V. Lazarus* **26**

**Cairo and beyond: Reproductive rights and culture**

*By Evert Ketting* **27**

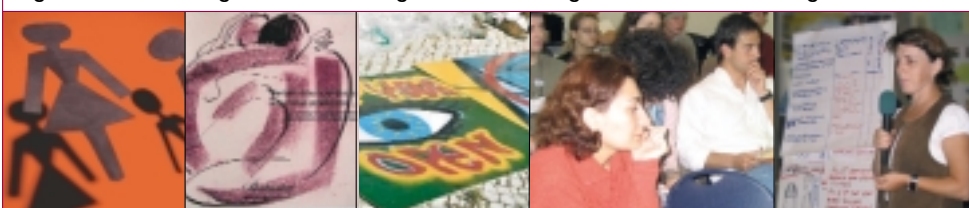
**Confronting HIV/AIDS: How NGOs can achieve greater youth involvement**

*By Lise Rosendal Østergaard, Bjarne B. Christensen and Jeffrey Victor Lazarus* **29**

**Resources**

**30**

Page 9      Page 13      Page 24      Page 25      Page 24



Cover illustration: © To ombord

## THE ENTRE NOUS EDITORIAL ADVISORY BOARD

**Dr Assia Brandrup-Lukanow**

Director, Division for Health, Education and Social Protection  
German Agency for Technical Co-operation (GTZ)

**Mr Bjarne B. Christensen**

Head of secretariat, Sex og Samfund, the Danish Family Planning Association

**Dr Helle Karro**

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

**Dr Evert Ketting**

Netherlands School of Public Health  
Utrecht, The Netherlands

**Dr Malika Ladjali**

Senior Programme Specialist  
UNESCO/Headquarters, Paris

**Ms Adriane Martin Hilber**

Technical Officer, Department of Reproductive Health and Research, WHO Headquarters, Geneva

**Ms Nell Rasmussen LLM**

Director, PRO-Centret, Copenhagen

**Dr. Peer Sieben**

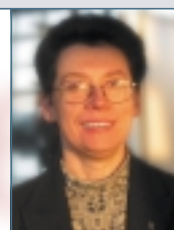
UNFPA Representative and Country Director, Romania

**Ms Vicky Claeys**

Regional Director  
International Planned Parenthood Federation, European Network (IPPF-EN), Brussels

**Dr Robert Thomson**

Adviser on Sexuality, Reproductive Health & Advocacy, UNFPA Country Technical Services Team for Europe, in Bratislava



**This issue of *Entre Nous* is dedicated to youth friendly health services (YFHS) and in this editorial we provide some background to why young people are important, why they need youth friendly services and what UNFPA, UNICEF and WHO have been doing to improve access to them.**

Adolescence and young adulthood is a time of all-encompassing transition – physically, mentally and socially. It is a time of experimentation and new experiences, and a time when young people make choices that have a profound bearing on the future course of their lives. Young people in central and eastern Europe are experiencing these characteristic ups and downs of the passage to adulthood, but there are differences in their experiences depending on whether they are viewed as a resource for the future and so seen as an investment in order for them to play a full role in society, or whether they are viewed as a problem and thus ignored. The socio-economic costs of not investing in the health and development of young people, including HIV prevention, are immense and will contribute to increased poverty and impede national development.

Along with these transitional changes, young people are profoundly affected by the alarming trends in the region: political and social instability, armed conflicts, discrimination towards ethnic groups and young women, increasing levels of violence and crime, the newly emerging phenomenon of trafficking in human beings (particularly young girls for the sex trade), decreasing investments in the social sector coupled with the poor state of the economy and widespread youth unemployment.

Recent surveys on the situation of young people in the region report increasing rates of injecting drug use and other forms of substance abuse (special-

ly alcohol and tobacco), and rapidly increasing rates of stress and mental ill health linked – in some countries – to alarming suicide rates amongst young men. An increasing number of young people are now homeless and on the street. Participation by young people in civic and political life is low. In addition, reproductive health indicators show that the prevalence of contraceptive use in many European countries is still low, abortion rates are high, maternal and infant mortality rates are increasing in some countries, and the incidence of sexually transmitted infections likewise shows an upward trend. HIV/AIDS is spreading faster in parts of the region than in any other part of the world and young people are at the centre of the epidemic. More than 80% of people who are HIV positive in the region have not yet turned 30. (In Ukraine, 25% of those diagnosed with HIV are younger than 20; in Belarus 60% of them are aged 15-24; while in Kazakhstan and Kyrgyzstan upwards of 70% of HIV positive individuals are under 30 years of age. In the Russian Federation, 80% of people infected with HIV are injecting drug users under 30). While the majority of infections are attributed to injecting drug use, sexual transmission of HIV is becoming more prominent.

There is an urgent need, therefore, to address these issues and to promote the healthy development of young people through services that are appropriate, affordable and accessible and integrated into a sustainable and comprehensive response to their needs. This includes access, and attention to, information and education, using approaches such as peer education and life skills, support for the participation of young people, the creation of safe and supportive environments including youth friendly services.

Young people and HIV/AIDS prevention and care have been accorded priority in global goals for young people and HIV/AIDS. The United Nations General Assembly Special Session on HIV/AIDS (UNGASS) and other international commitments (for example the Dublin Declaration) call for accelerated action at the national level, especially for a health systems response through the provision of youth friendly health services to contribute to the fight against HIV/AIDS.

We know what works: the provision of information and counselling, particularly directed to skills and knowledge acquisition, condoms, sexually transmitted infection treatment and care, harm reduction measures for injecting drug users and access to HIV testing, care and support are effective in reducing HIV transmission and meeting the sexual health needs of young people in a variety of settings.

Young people have a right to health services to ensure universal and equitable access to services for prevention, treatment and care regardless of age, gender, sexual orientation or socio-economic status.

The health system has a major role to play in youth friendly health services and has a clear responsibility to ensure that young people have access to the services and supplies they need. Strategic evidence-based information should be available to plan and monitor national programmes, and promote youth friendly policies. Furthermore, experiences and lessons learned need to be documented and widely disseminated. Some of these are presented in this issue of *Entre Nous* magazine.

We would like to thank the United Nations Inter-Agency Group on Young People's Health, Development and Protection in Europe and central Asia, Sub-group on Youth Friendly Services for their contribution to this editorial.

**Dr Gunta Lazdane**  
[gla@who.dk]  
Chief editor

**Jeffrey V. Lazarus**  
[jla@who.dk]  
Editor

# SENSITISATION OF MAYORS IN LITHUANIA TO THE CONCEPT OF YOUTH FRIENDLY SERVICES

Hilary Homans and Agne Bajoriniene

**O**n a snowy day in January 2004, 121 participants braved the adverse weather conditions to attend a conference on youth friendly services (YFS) in Lithuania. The meeting was held in the town hall in Vilnius and was formally opened by the Mayor of Vilnius, Mr Artūras Zuokas. Present were 39 mayors, deputy mayors or their nominees, representing 36 out of the 60 municipalities in Lithuania, as well as representatives of academia, the Association of Local Authorities in Lithuania, the government, the media, educational, social and public health sectors, international and national non-governmental organizations (NGOs), the United Nations and youth organizations.

The objectives of the conference were to sensitise mayors and key personnel in Lithuania to the concept of YFS, provide examples of how these services are being implemented in other countries in Europe, describe examples of existing good practice in Lithuania, and introduce participants to the Government of Lithuania/UNDP, UNFPA and UNICEF youth friendly services project being implemented in six municipalities.

The Minister of Education and Science (Mr Algirdas Monkevičius), the Minister of Health (Dr Juozas Olekas), the Secretary of State from the Ministry of Social Security and Labour (Ms Violeta Murauskaite) and the United Nations resident coordinator (Ms Cihan Sultanoglu) all stressed the need for young people to participate actively in the promotion of their health and development. This is a multisectoral task and requires strong partnerships between government, the private sector, NGOs and youth organizations. Mayors have an important role to play in promoting and protecting the health and rights of young people in Lithuania, in accordance with the Convention on the Rights of the Child.

The concepts of youth friendly services and youth friendly health services, with examples from other countries, were presented and complemented by presentations on the current status of services within Lithuania:

- peer education and young people's access to information (Ms Inga

Aksamitauskaitė)

- health promoting schools (Dr Aldona Jociūtė)
- mental health (Mr Paulius Skruibis)
- adolescents' reproductive health care services (Dr Lina Jaruševičienė)
- prevention of substance use and collaboration with the municipality (Dr Emilis Subata)
- national HIV/AIDS programme and youth friendly services (Dr Saulius Čaplinskas).

All presentations were consistent in their approach. Young people have a right to YFS and whilst there are some excellent examples of these services within Lithuania, most of them are located in the capital or large cities (with limited coverage), and young people in rural areas have little access to services. There is clearly a need to go to scale with these initiatives and to expand them based on the needs of young people and on Lithuanian values, and, as in the Klaipėda case study of peer education, to actively involve the church and parents.

Representatives of the Lithuanian Youth Parliament and the NGO "In Corpore" stressed the pressing need to develop life and livelihood skills in young people and to address their reproductive health needs through education and training.

## Next steps

The Government of Lithuania launched a youth friendly services project on 30 September 2003. The project aims at strengthening or expanding youth friendly services in six municipalities. The overall goal of the project is to promote young people's health, development and protection and to limit the spread of HIV/AIDS among young people in Lithuania. It is widely recognized that HIV/AIDS is not an issue to be addressed by the health sector alone. HIV transmission occurs within a complex set of social structures and interpersonal relationships, and can be intensified by cultural, economic, geographical, physiological, social and other factors.

Young people account for the majority of new infections and are facing a crisis of vulnerability to HIV infection. But they are not the problem. Rather, they

represent the greatest opportunity to defeat HIV/AIDS. Their active participation in prevention and care efforts is crucial, and those who are especially vulnerable must be included. Prevention of HIV/AIDS among young people is addressed by governments and United Nations agencies as a priority issue in the context of the Millennium Development Goals ([www.un.org/millenniumgoals/](http://www.un.org/millenniumgoals/)).

The final presentation was on how YFS mapping will be conducted in each of six municipalities. It is important to stress that the scope of the project goes well beyond these six municipalities. The curricula being developed on a wide range of topics (adolescent health and development, communication and counselling, outreach services, peer education and how to provide YFS) will be available for use by all municipalities and should be integrated into basic training programmes for a range of professionals. Strategies are already in place to disseminate information and lessons learned from the pilot project to all municipalities and a web page will be established for this purpose. It is also proposed that there will be an annual mayors' meeting throughout the duration of the project for all municipalities to share experiences in applying the lessons learned.

Every corner of Lithuania was represented at the meeting despite the poor weather conditions. The central message was that every young person is precious, with a future which we, as adults, have a role to nurture and develop with the active collaboration of young people themselves. The Lithuanian YFS project has been designed to facilitate this process and the key to its success will be partnerships and working together.

**Hilary Homans**  
[[hhomans@unicef.org](mailto:hhomans@unicef.org)] United Nations Interagency Group  
Consultant on Youth Friendly Services

**Agne Bajoriniene**  
United Nations Interagency  
Coordinator on Young People's Health and Development in Lithuania

All conference publications are available on the State Public Health Service website ([www.vvspt.lt](http://www.vvspt.lt)) and it is proposed to run a series of articles on the conference presentations in the Lithuanian Association of Municipalities Newsletter.

Different Lithuanian institutions have placed their information related to the event online as well: Portal of Lithuanian Municipalities ([www.savivaldybes.lt](http://www.savivaldybes.lt)), Lithuanian Association of Local Authorities ([www.lsa.lt](http://www.lsa.lt)), Health Portal ([www.sveikas.lt](http://www.sveikas.lt)), Ministry of Education and Science ([www.smm.lt](http://www.smm.lt)), Vilnius city municipality ([www.vilnius.lt](http://www.vilnius.lt)), State Public Health Service ([www.vvspt.lt](http://www.vvspt.lt)), UNDP Lithuania ([www.undp.lt](http://www.undp.lt)).



# A DECADE OF YOUTH CLINICS IN ESTONIA

By Kaie Toomet, Kai Part and Kai Haldre

Youth clinics in Estonia were founded ten years ago by local enthusiasts, but without any systematic coordination and regular funding. The Estonian Family Planning Association (FPA) later took the youth clinics under its wing, organized training for youth clinic staff, and compiled and published sex education literature.

Irregular funding was for many years a common concern for the youth clinics. However, since 2002 the Estonian Health Insurance Fund has financed the testing for sexually transmitted infections (STIs) and sexual health counselling in youth clinics as part of a five-year project. There are currently 16 youth clinics in Estonia, two of them are run as private limited companies, two as private practices by gynaecologists and the rest as units of larger health care institutions. The numbers of visits differ at each clinic and their working hours vary from 4 to 40 hours per week.

## Youth clinics: why and for whom?

The clinics are intended for young people of both sexes up to the age of 24. Visits to the clinic are voluntary and the service is free. The counselling principle is considered to be important; this means that clients are given sufficient information to make necessary decisions themselves. The clinics are, if possible, kept separate from other medical establishments and waiting lists are kept as short as possible. In the clinic young people must feel secure and welcome and treated with respect.

## The following services are provided:

- Individual and couple counselling – by a gynaecologist or midwife and, in some clinics, by a urologist, psychologist or social worker. There is separate counselling for boys/men in the three largest clinics and testing for STIs including HIV. Other services include contraceptive counselling, abortion counselling, counselling for victims of sexual violence and psychosexual counselling;
- Sexual education lectures for students: interactive methods are used in order to promote discussion and the development of positive attitudes. In 2003 the lectures were funded by the Estonian Health Insurance Fund and the

Table 1. Prevalence of STIs among Estonian youth clinic visitors in 2002 and 2003, who were tested for sexually transmitted infections.

	Positive diagnoses/tested population 2002	Prevalence rate (%) 2002	Positive diagnoses/ tested population 2003	Prevalence rate (%) 2003
Gonorrhoea	40/2340	1.7	57/2394	2.4
Chlamydia	455/2925	15.6	466/3975	11.7
Syphilis	0/555	0.0	0/703	0.0
Trichomonosis	163/3612	4.5	230/4650	4.9
HIV	9/517	1.7	5/734	0.7

National Institute for Health Development. In 2004 the lectures are being funded by the Global Fund;

- Online counselling was initiated in 1998 with the help of the Open Estonia Foundation. Today it has developed into [www.amor.ee](http://www.amor.ee), hosted by the Estonian FPA. E-mails are answered by a team of 30 specialists consisting of gynaecologists, urologists, a sexologist, psychologists and a social worker. In 2002, online counselling was funded by the United Nations Population Fund, and from 2003 to 2005 by the Estonian Health Insurance Fund.

## Facts and figures

### Number of visits

In 2003 a total of 22 676 visits were made to youth clinics. Of these, 30% were connected with testing for STIs and 70% with contraception and other counselling. Of the visits 96% were made by women and 4% by men; 45% were by 15-19-year-olds and 55% by 20-24-year-olds.

### Lectures

In 2003, 550 sexual education lectures and seminars involving 7 950 10-19-year-old students were held.

### Online counselling

In 2002, 872 letters were answered; in 2003, 2 235 letters and in the first two and a half months of 2004, 1026 letters have already been received. This service is evidently rapidly growing in popularity. In 2003, 78% of correspondents were women and 22% were men.

## Prevalence of STIs

Table 1 below shows that the prevalence of STIs diagnosed among youth clinic visitors in 2003 remained at the same level as 2002, or even rose. Screening of Chlamydia and other STIs is offered to youth clinic visitors complaining of the relevant symptoms, known to engage in risky behaviour (i.e. having new or multiple sexual partners and/or unprotected intercourse), or on a yearly basis for asymptomatic sexually active visitors.

In 2002, many youth clinics began to use the polymerase chain reaction (PCR) method, which has improved the quality of diagnoses. The prevalence of gonorrhoea and trichomonosis among the screened population has risen and that of chlamydia has fallen slightly, but the figures are still very high. Screening for chlamydia, which is often asymptomatic, is important because it can cause serious complications in later life.

The prevalence of HIV among the examined population is relatively small considering Estonia's epidemiological situation (in 2003, 840 new cases of HIV were diagnosed in Estonia, mostly among those under 25 years of age). Presumably, members of the main HIV risk group (injecting drug users) are under-represented among youth clinic visitors. The proportion of sexually transmitted HIV infection is expected to rise. Thus, it is important to offer youth clinic visitors even better opportunities for HIV testing and counselling.

## Teenage pregnancies

The numbers of teenage abortions and births in Estonia have decreased substantially between 1992 and 2001 (1-2). The number of live births per 1000 among

# A WORRISOME SITUATION!

*Sexual and reproductive health services in t*

15-9-year-old women was 49.7 in 1992 and 23.8 in 2001 (1-3). In 1992, 14.6% of those giving birth were teenagers and in 2001, 9.8%. The number of legally induced abortions among 15-19-year-olds has almost halved: the abortion rate per 1000 for 15-19-year-old women was 55.5 in 1992 and 30.4 in 2001. Given the overall reduction in abortions, the percentage of teenagers among abortion patients has risen from 11.4% in 1992 to 13.5% in 2001. This trend is similar to that of high-income countries: unplanned pregnancies occur more often among teenagers, who rarely choose to give birth.

A big gap between ethnic groups is also noticeable. 15-19-year-old non-ethnic Estonians had up to a third more induced abortions per 100 live births than ethnic Estonians. This presumably is a result of differences in sexual culture and attitudes regarding contraceptives. These findings show that we must make counselling available to youth in their early teens and that counselling work among non-ethnic Estonians must be stepped up.

## Satisfaction of visitors

In 2003, an online survey to assess satisfaction with the work of the youth clinics was conducted. Of the 378 respondents, aged 13-25, (94% female and 6% male), the majority (94%) considered the work of the clinics to be very good or good, 5%, to be average, and 1% to be bad.

The youth clinic visitors appreciated most the personal traits of the staff (e.g. friendliness, caring), their attitude towards young people (e.g. tolerance, non-judgementalism), and professionalism (e.g. ability to listen and to explain clearly), and the comfortable and friendly atmosphere which, according to the respondents, did not resemble that of other medical establishment.

Respondents also praised the STI counselling and testing opportunities and the good accessibility of the service (e.g. short waiting lists, free service).

Improvements were primarily suggested with regard to factors affecting the accessibility of the service: waiting lists, telephone connection, lack of space, opening hours, number of staff and proximity of nearest clinic. It was suggested that the clinics should do more to

advertise themselves in schools and in the media. Many were reluctant to turn to the women's clinic or to their family doctor with their problems. For many reasons, e.g. youth orientation, professional staff, recommendations from friends, young people find it easiest to seek help from youth clinics.

This confirms what many countries have found in practice, i.e. that, in order to reduce sexual health related risks, young people must have access to their own youth-friendly counselling services. The Estonian youth clinics have so far certainly proved their worth, and we hope that their existence and ability to provide youth-friendly health services will be maintained.

## References

1. Tellmann A, Karro H, Serkina V. Estonian Medical Birth Registry 1992-2001. Estonian Abortion Registry 1996-2001. Tallinn: EKMI; 2002 (in estonian)
2. K Haldre, H Karro, M Rahu. Reproductiivtervise näitajad Eesti nais- tel 1992-2001. Eesti Arst 2003; 82(3): 166-171
3. Eesti Statistikaamet. (Statistical Office of Estonia) <http://gatekeeper.stat.ee:8000/px-web.2001/dialog/statfilere.asp>

## Kaie Toomet

[eppl@amor.ee]  
Estonian Family Planning Association, programme coordinator, psychologist and youth counsellor

## Kai Part

[kai@amor.ee],  
gynaecologist and youth counsellor

## Kai Haldre

[kai.haldre@kliinikum.ee],  
gynaecologist and youth counsellor

Already in the 1990s the Dutch Ministry of Health decided that sexual and reproductive health services should be integrated in primary health care. In those days, the Dutch Family Planning Association 'Rutgers Foundation' had almost 60 clinics established for sexual and reproductive health care, scattered about the country. These clinics, the so-called 'Rutgershuizen' (Rutgers houses), were well known and because of their youth friendliness young people went to the clinics for contraceptives, information and care. Due to this decision to have no special services for sexual and reproductive health, and because of the reduction in financial subsidies, only seven clinics, in the major cities of the Netherlands, were left. Due to a further cut in funds and a reorganization of the Dutch Family Planning Association, the seven clinics were transferred to abortion clinics in 2002/2003.

The idea was to establish centres where one could receive care for all sexual and reproductive health questions and problems, including abortion. This integration of abortion services with services for sexual and reproductive health care was politically provocative. The result was that the Ministry of Health decided to have two entrances for these new 'centres for sexuality'; one entrance for abortion care, the other entrance for sexual and reproductive health care. This was a solution to ensure that groups of women and girls who do not for religious or other reasons agree with abortion, are comfortable with entering the centre.

The transfer of the seven former 'Rutgershuizen' into abortion services led to a misunderstanding among the general public. People, especially young people, thought that the clinics were closed, general practitioners (GPs) and other medical doctors did not refer clients anymore. And many women/girls dislike entering a service that was previously known as an abortion service. This resulted in a decline in the number of clients.

Now that service of sexual and reproductive health are integrated in primary health care, GPs are the main source of information on sexual and reproductive health, also for young people.

Recent research among GPs on information about contraceptives provided to

# PREVENTING AND COMBATING HIV IN RUSSIA, PHASE I

the Netherlands

by Anke van Dam

By Olga de Haan

girls under 20 show that 23% of the GPs report not having sufficient time to discuss contraceptives properly. The GPs refer the girls to information on websites and in leaflets.

Research among the girls under 20 on their perception of the role of the GP with regard to give information on contraception showed that the information from the GP about the contraceptive pill is not sufficient. Between 10% and 46% of the girls reported that they had not received "important" information.

In recent years there has been an increase in teenage pregnancies and sexually transmitted infections, including HIV, in the Netherlands (1). It is time to reconsider the Dutch policy in the field of sexual and reproductive health services for young people and consider a partial return to the past.

*Additional literature is available from the author.*

## References

1. Berlo WTM van, Brook OH, Brewaeyns A and Nieuwenhuysen H. (in preparation). "Information on contraception received from the general practitioner. A study among schoolgirls and general practitioners".

## Anke van Dam

[a.vandam@rng.nl]

Head of Department, Innovation and Development from Rutgers Nisso Group, the Netherlands expert centre on sexuality (the merger of the Rutgers Foundation and NISSO, Netherlands Institute of Social Sexological Research).

## "Preventing and combating HIV in Russia" is the title of an EU-funded project that was launched in January 2004.

During this two-year project a comprehensive approach to HIV prevention will be taken, targeting different levels of society, varying from schoolchildren to federal decision-makers. All activities aim on the one hand at raising awareness that HIV is an important matter for all of us, and at the same time promoting behavioural changes, from safer sexual practices to a reallocation of the federal budget in favour of HIV prevention and treatment.

The international consortium who is implementing the project reflects the comprehensiveness of this approach, and it consists of the UK charity International Family Health, the Dutch STI AIDS Foundation, The Siberian non-governmental organization Humanitarian Project and the Russian Agency for Social Information and IMC Consulting Ltd, a British company. The main partner is the Federal Aids Centre and the beneficiaries include the Regional Aids Centres in two pilot regions, the Buryatiya republic and the Ulyanovsk region as well as young people from those regions. In these regions, the main part of the project will be realized through:

- a school subject on HIV-prevention for 10th and 11th graders, focusing on HIV prevention and other unintended outcomes of unsafe sex, such as sexually transmitted infections and teenage pregnancies. The subject is not only putting into the children's heads information on how to prevent themselves from becoming infected, but also supports the formation of a positive attitude towards sexual and reproductive health and rights;
- for all young people in the region, the development of youth friendly sexual and reproductive health services will be supported and implemented, where possible. The first step will be the training of regional health care providers on communication and counselling, and follow-up trainings on how to set up youth-friendly ser-

vices, with practical and technical assistance from the project in implementing these service;

- an advocacy programme to promote HIV-prevention programmes within middle- and large-sized enterprises in the region, targeting the management of at least ten enterprises to develop and launch a solid HIV-prevention programme at their workplace and invest their own capital in the implementation of this prevention programmes;
- an awareness raising and information campaign targeting young people, from schoolchildren to the employed, on safe sex, sexual and reproductive health and rights will be launched in both regions, with the close cooperation of local NGOs and the local mass media.

The overall aim of the project is to forge a solid and sound intervention to stop the spread of HIV/AIDS through coalition building activities between active youth NGOs and local authorities.

Though most activities aim to empower the regional AIDS centres, on the federal level the project will contribute to:

- a shift in the allocation of the federal budget in favour of prevention policies (through advocacy activities); and
- the empowerment of the Federal AIDS Centre through technical assistance for improving multisectorial coordination with national and international stakeholders

## Contact information:

IMC-Moscow, tel.: +7-095-2506717,

fax: +7-095-2515962

Team leader Boris Sergeyev

[boris\_s@imcgroup.ru]

Primary prevention/mass media

## Olga de Haan

[olga\_h@imcgroup.ru]

IMC Consulting Ltd.

# ASSESSING YOUTH-FRIENDLY HEALTH SERVICES IN THE RUSSIAN FEDERATION

*Tatiana Kozhukhovskaya, Paul Bloem and Karina Vartanova*

Health services friendly to young people are not entirely new to the Russian Federation. During the Soviet period, “adolescent cabinets” provided a limited range of services, including extensive screening. In 1993, Yuventa, the St. Petersburg City Consultation and Diagnostic Centre on Adolescents’ Reproductive Health, under the City Health Committee, pioneered the broader concept of youth-friendly services (YFS). It was the first health clinic in the Russian Federation to provide sexual and reproductive health services exclusively for adolescents. Inspired by the youth consultation network in Sweden and the Brook Advisory Centres in the United Kingdom, Yuventa now logs nearly 250 000 visits every year.

In the past decade, through UNICEF and UNFPA support, more experience was gained with YFS in the Russian regions, an essential approach due to decentralization in the health sector.

The main inputs provided were protocols to establish and run clinics; essential drugs, equipment and supplies particularly condoms; and health professionals were trained in youth health needs. Youth volunteers were trained in peer education and counselling. Culture- and age-relevant information, education and communication materials were developed for the clinics. Finally, clinics were encouraged to lobby local health authorities for YFS support.

As a result of the experiences, the Ministry of Health has grown steadily more interested in YFS. In 2001, the Ministry and the Medical Academy of Postgraduate Education in St Petersburg concluded that 15 regions had YFS. Yet a long way remains to go. Though data are lacking, it is clear that the percentage of Russian adolescents with access to YFS is small, particularly in rural areas.

There are promising attempts to widen coverage. In the St Petersburg area, where more than 1 million of the 5 million inhabitants are young people, Yuventa collaborated with local health authorities to develop a network of 12 youth-friendly counselling and referral centres to guarantee access. Yuventa functions as a central referral centre, and local primary services throughout the city provide basic services.

Quality, cost and coverage are three interrelated aspects of YFS. Quality means ensuring that services meet young people’s needs. Cost is important to not only adolescents but also health planners. Coverage is important in addressing public health issues like STIs. In late 2002, WHO, UNICEF and UNFPA began systematizing experiences with adolescent-friendly health services, focusing on these three aspects. This study is one result.

## The conceptual framework for YFS quality assessment

WHO developed a seven-part framework for adolescent health services:

1. adolescent-friendly policies and guidelines;
2. adolescent-friendly health facilities;
3. adolescent-friendly procedures;

4. adolescent-friendly health care providers and support staff;
5. adolescent participation;
6. comprehensive and effective services;
7. efficient services.

It was used to create a standards-based quality improvement approach to YFS. To measure YFS quality, WHO developed a toolkit from existing assessment tools. Three components assess health facility management, the staff and the adolescent clients. In early 2003, tools combining external assessment through observation of services with self-reporting by staff and clientele were tested in Tomsk, Siberia, as part of a global evaluation of the UNF project Meeting the participation rights of adolescent girls.

## Methodology

The assessment was conducted in seven sites in western Siberia. The sites were all supported by the UNF through UNICEF or UNFPA.

1. Barnaul – a youth-friendly clinic (YFC) attached to the Regional AIDS-Prevention Centre;
2. Barnaul – YUNIKS Centre in Barnaul Municipal Hospital;
3. Biisk – a YFC in Biisk Municipal Center for Preventing and Combating AIDS and Other Diseases;
4. Novosibirsk – Yuventus Centre, close to the city train station, its 1993 transformation into a youth service supported by the local health and youth affairs authorities;
5. Novosibirsk – another YFC in Municipal Specialized Children’s Hospital #5;
6. Tomsk – Youth Medical Center (YMC), targeted at students; and
7. Tomsk – Our Clinic, a small stand-alone centre affiliated to the AIDS Centre, targeting youth who are injecting drug users and commercial sex workers (CSWs).

With the exception of Yuventus, which started more than 10 years ago, the sites had been YFS for two or three years. The YFCs in Biisk and Novosibirsk had been YFS for the shortest time. Most sites target both adolescents (10 to 19 years) and older young people (up to 24 years).

An external consultant team assessed the sites. They interviewed the facility managers and had some or all staff members including young volunteers fill in





questionnaires. They also surveyed 50 randomly selected clients at each site through anonymous exit questionnaires.

## Results

### Impressions of a youth friendly service in Barnaul

The Altai Regional Center for the Prevention and Combating of AIDS and Other Diseases in Barnaul has its own entrance. The YFC premises look not like a newly renovated European-style clinic but like other regional AIDS centres or traditional medical institutions. Entering, however, you immediately notice posters obviously aimed at adolescents. They address drugs, STI transmission, STI protection and contraception. Booklets with similar information lie on the table. The posters imply that you can discuss these issues here, ask questions and receive the answers you need. Several young girls are in the waiting room, unembarrassed about consulting a gynaecologist – they either have been here before and feel at home, or they know they will be treated with attention and respect. The staff does seem different. They smile openly and are clearly friendly and interested, not the usual mix of strictness, chronic weariness and distance you normally face elsewhere.

**Table 1. Sociodemographic characteristics of youth clinic clients**

	Variables	Number	%
Sex	Female	290	80.6%
	Male	70	19.4%
Age	13–15 years	35	9.7%
	16–18 years	207	57.5%
	19–21 years	81	22.5%
	Older than 21 years	37	10.3%
City	Barnaul	104	28.9%
	Biisk	50	13.9%
	Novosibirsk	106	29.4%
	Tomsk	100	27.8%
Residence	Hostel	74	20.6%
	With friend/partner	33	9.2%
	With parents	227	63.1%
	Own apartment	26	7.2%
Social status	Professional education	49	13.6%
	University students	175	48.6%
	Vocational school students	61	16.9%
	Unemployed	75	20.8%
TOTAL		360	100.0%

**Clinic staff.** 95 paid staff members, 76% of the total, and 11 youth volunteers filled out the staff questionnaire. All 7 managers were interviewed for the facility survey.

### Client satisfaction

Table 2 shows client satisfaction with services and organization. No statistically significant differences were observed

between males and females, but major differences were observed between younger and older clients, as well as between various sites.

**Table 2. Client satisfaction scores**

Indicators	Youth clinic	Barnaul I AFG	Yuniks	Büsk YFC	YMC	Our Clinic	Yuventus	Novosibirsk YFC
<b>Total client assesment</b> (mean score)		33 (2.8)	46 (3.8)	43 (3.6)	40 (3.3)	49 (4.1)	42 (3.5)	30 (2.5)
<b>Confidentiality and privacy</b> Possibility of visiting the centre without family consent		4	5	5	5	5	4	3
Confidence that visits will remain anonymous		3	4	4	4	4	4	2
Satisfaction with privacy and confidentiality after visiting		3	2	4	3	4	3	3
Clients informed about								
• working hours		2	4	3	3	3	3	2
• tests and examinations		3	4	3	3	5	4	2
• examination results		3	4	4	4	4	4	4
• treatment prescribed		2	5	4	4	3	4	3
• other recommendations		2	5	3	3	4	4	2
<b>Availability of information</b> (materials in waiting area)		3	4	3	4	5	3	3
<b>Accessibility</b> Possibility of free assistance		1	2	4	1	5	2	1
<b>Affordability</b>		3	2	1	2	2	3	2
<b>Equal access for both sexes</b>		4	5	5	4	5	4	3

**Satisfaction levels** (as % of affirmative answers): 1 = <30%; 2 = 30% to 49%; 3 = 50% to 69%; 4 = 70% to 89%; 5 = >90%.

Overall confidentiality and privacy scores were quite good, with often more than 90% (level 5) reporting no consent was needed. Three quarters were confident that relatives would not find out. Interestingly, only 25% of clients between 13 and 15 were confident of this.

Detailed analysis showed that overall satisfaction with privacy and confidentiality ranged considerably not only by service (42% to 81%) but also by staff position. Overall, 85% of clients thought doctors provided services confidentially, while 75% thought nurses and receptionists did.

Score differences between clinics indicate the possibility of achieving high quality through clear policies and a well-trained, motivated staff. While Our Clinic scored consistently high for all types of staff, employees elsewhere were not equally well prepared.

Information received by clients can also indicate the quality of staff procedures and training. About 75% of clients reported they received sufficient information on opening hours, examinations and treatment.

One access factor is affordability of paid services and the possibility of obtaining free assistance if needed. Many facilities provide fee services to clients older than 18. Some places, certain special services are always paid for. Several facilities scored quite low in this category. An exception is Our Clinic, which appears acutely aware what a barrier fees are to the CSWs and drug users it serves.

Most youth clinic clients are female (80%). One aspect of quality is whether facilities cater equally to adolescent males and females. Most clients felt services were equally accessible and welcoming to both. Even though boys use the services less often, they found the services even more equally welcoming than girls (91% to 81%).

The average satisfaction score was about 3.8, meaning nearly 70% of clients were satisfied with each item. More than 90% of Our Clinic clients felt satisfied in 5 of the 12 categories.

#### Client-provider interaction

Table 3 focuses on the perceived quality of the interaction between health worker and adolescent during consultation. It does not include some important care

**Table 3. Client assessment of health provider interaction**

Items (% answered affirmative)	Barnaul	Yuniks	Biisk	YMC	Our Clinic	Yuventus	Novosibirsk
Did the health worker introduce himself/herself?	26%	70%	52%	64%	92%	68%	39%
Did you feel at ease and relaxed with health worker?	83%	88%	92%	84%	88%	90%	51%
Did health worker explain sufficiently?	57%	90%	68%	74%	96%	84%	60%
Were clients treated with due respect?	68%	90%	94%	86%	98%	90%	36%
<b>Total</b>	<b>58%</b>	<b>85%</b>	<b>77%</b>	<b>94%</b>	<b>83%</b>	<b>77%</b>	<b>47%</b>
Level	3	4	4	4	5	4	2

Levels

(% of affirmative answers): 1 = <30%; 2 = 30% to 49%; 3 = 50% to 69%; 4 = 70% to 89%; 5 = >90%.

**Table 4. Client and employee assessment of youth clinic performance**

Criteria	Barnaul YFC		Yuniks		Biisk YFC		YMC		Our Clinic		Yuventus		Novosibirsk YFC	
	Clients	Staff	Clients	Staff	Clients	Staff	Clients	Staff	Clients	Staff	Clients	Staff	Clients	Staff
Convenient waiting area	3	4	4	5	3	–	4	3	4	5	3	1	2	4
Providers introduce themselves	1	4	4	4	3	4	3	4	5	4	3	3	2	3
Confidentiality before third parties	3	4	4	4	4	5	4	5	4	5	4	2	2	3
Confidentiality and privacy	3	5	2	5	4	5	3	5	4	5	3	4	3	5
Professional competence of staff	3	4	5	3	4	4	5	2	5	4	5	4	2	5
Participation of adolescents	2	1	1	5	1	–	1	5	3	4	1	1	1	–
Equal access for males and females	4	4	5	5	5	4	4	5	5	5	4	5	3	2

Levels

(% of affirmative answers): 1 = <30%; 2 = 30% to 49%; 3 = 50% to 69%; 4 = 70% to 89%; 5 = >90%.

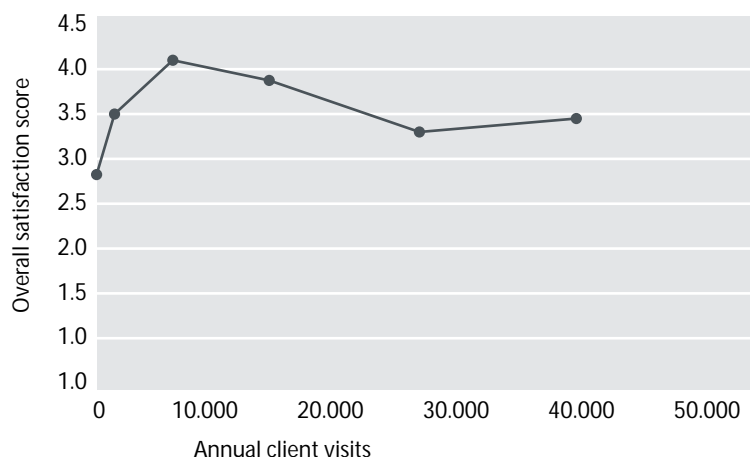
**Table 5. Integrated assessment of YFS performance**

Criteria	Barnaul YFC	Yuniks	Biisk YFC	YMC	Our Clinic	Yuventus	Novosibirsk YFC
Convenient waiting area	B	C	–	B	C	A	A
Providers introduce themselves	A	C	B	B	C	B	A
Confidentiality before third parties	B	C	C	C	C	A	A
Confidentiality and privacy	B	B	C	B	C	B	B
Professional competence of staff	B	B	C	B	C	C	B
Participation of adolescents	A	A	–	A	B	A	–
Equal access for males and females	C	C	C	C	C	C	A

parameters (establishing rapport and trust, explaining treatment etc.). No direct observation was carried out to verify client perceptions. Nor were other quality parameters assessed, such as efficiency.

At five sites, more than 75% of clients were satisfied with health worker performance. At the other two, remedial training might improve interaction quality. Employee self-introductions could be improved at most sites.

**Fig. 1. Client satisfaction and service utilization**



Another questionnaire was developed to provide a useful reality check by triangulating staff and client perspectives. Table 4 indicates a generally good concordance between the two groups' opinions. However, they sometimes held diametrically opposing views, e.g. on adolescent participation in Yuniks and professional competence in YMC.

Finally, the client and staff scores in Table 4 were multiplied to yield an integrated assessment score for each item, which was then assigned to one of three levels: Level A scored 1 to 8; Level B, 9 to 15; and Level C, 16 to 25 (Table 5).

Our Clinic also uses a professional outreach programme to encourage CSW participation, but no statistics are available.

Fig. 1 shows no apparent correlation between overall client satisfaction and utilization, implying that busy facilities can provide quality services. Note that no opinions were solicited from adolescents who did not use the services.

Some sites survey their target populations occasionally and claim a contact coverage (the percentage reached though preventive or curative services) of between 8.0% (Yuventus) and 20% (Our Clinic).

Many projects use peer education to distribute preventive messages, condoms and information about available services. Our Clinic also uses a professional out-

reach programme to encourage CSW participation, but no statistics are available.

### Discussion and conclusions

This study, the first to quantify the quality of YFS in the Russian Federation, was conducted by a national expert with support staff, in collaboration with UNICEF Russia and WHO Headquarters. Lacking national standards for YFS that would facilitate assessment, it relied upon generic criteria developed by WHO. WHO believes that measurement is essential to quality improvement in service provision. The Millennium Development Goal for HIV reduction states that, by 2010, "95% of young people should have access to [information, life skills and] services". YFS first appeared in the early 1990s in St. Petersburg and Novosibirsk, and today about 20 institutions operate according to YFS principles. A paradigm shift is needed to provide full access to services in order to achieve the HIV-reduction goal. St. Petersburg's Yuventa (see Introduction) provides one possible direction.

The sites examined represent different care models, ranging from a large semi-independent clinic that serves as a referral centre, to facilities focusing on primary care, to stand-alone centres targeting difficult-to-reach young people. Fig. 1

shows that, regardless of size, these different models can provide similar-quality services. The Russian health sector needs to address two key questions. First, which models can best reach the various sub-populations of young people, including rural adolescents? Second, which ones are most sustainable under current health reforms? WHO Global Consultation on Adolescent-Friendly Health Services recommends that existing services be made adolescent-friendly, rather than just promoting specialized stand-alone services. The country is now experienced with the latter. Its next challenge is to develop complementary service models to implement at the feldsher level.

The Russian Federation lacks a strong regulatory framework for YFS. This makes regional and local attempts to provide them more difficult and often dependent on personal involvement by territorial healthcare authorities. Efforts by youth clinics and sympathetic health authorities have led to the inclusion of YFS in various policy statements. We hope this study will promote YFS in health reforms and in policy discussions of care models and quality standards in order to maximize coverage for young Russians.

**Dr Tatiana Kozhukhovskaya**  
[juventa@front.ru]  
Deputy Director of the Yuventa  
Clinic, St Petersburg, Russian  
Federation

**Mr Paul Bloem**  
[Bloemp@who.int]  
Technical Officer WHO  
Headquarters

**Ms Karina Vartanova**  
[kavartanova@unicef.org]  
UNICEF Russian Federation

### Acknowledgements

This study was funded by United Nations Foundation funds and executed by WHO in collaboration with UNICEF - Russian Federation. The principal investigator was Dr Tatiana Kozhukhovskaya who was supported by local researchers. The authors want to express their gratitude towards the facility managers and staff as well as the young people who participated in the study.

# YOUNG DECISION-MAKERS OF EUROPE TAKE UP THE

*Building coalitions with young politicians to promote young peoples' sexual and reproductive health and rights*

*By Isabelle Sannestedt and Victor Bernhardt*

There are two common perceptions of young people. The first is that young people are the 'future', the hope of the world and a generation which knows no borders and one which will bring peace and prosperity to us all. The other common perception is one of young people being ignorant, lazy, drug abusers and generally out of place in society. Of course, neither of these images applies very well. Everywhere around the world there are young people who engage in activism and politics.

For the past two years the Swedish Association for Sexuality Education (RFSU) has worked together with young politicians and other young decision-makers. The aim of this collaboration has been to enhance advocacy for young peoples' sexual and reproductive health and rights (SRHR). So far, the outcomes of the project have been very promising. Debates in national and local newspapers, radio interviews, local seminars, national campaigns have appeared across Sweden reaching over one hundred thousand young students. But first, what is a "young decision-maker" and why should one work with them?

Young people do not necessarily see themselves as "the future, but those found in youth leagues of parliamentary parties, youth NGOs, networks of youth activists as well as in "ordinary" political movements are young decision-makers. While they may be the ministers, parliamentarians, directors and civil servants of tomorrow, they also exercise influence on the politics and thinking of young peoples of today.

The SRHR community has long been very effective at establishing relationships with decision-makers such as politicians and civil servants. For the past two years a pilot project by RFSU has attempted to establish the same link with the young decision-makers of Sweden. An NGO advocating for young people's SRHR logically has an interest in young decision-makers. Young decision-makers also have a responsibility to address SRHR issues. Young people, especially young women, are the most exposed group when sexual and reproductive rights are not respected. Therefore, working with an NGO can strengthen the young decision-makers' capacity to address the SRHR agenda. This has both short and long term effects on political relationships between NGOs

and decision-makers.

Young decision-makers representing youth leagues of parliamentary parties and youth NGOs have established a network in Sweden with the support of RFSU. The network is characterized by being informal in its structures and flexible to suit all organizations involved. This is a consequence of the nature of youth politics. 'Adult' politics are characterized by structures that all stakeholders act within, such as parliament and political parties. Youth politics are characterized by the absence of such structures. Of course, politically active youth relate to decision-making structures when influencing mother parties or parliamentarians, but this is only one of many target groups for young decision-makers. They also address students, youth with a job, youth without a job and other youth groups as well as the general public.

In Sweden young decision-makers wield significant influence in politics by pushing their mother parties on progressive debates and issues, through rallying young voters and through media attention. Young decision-makers advocate not only for their views on the issues debated by adult decision-makers but also specifically bring youth issues and youth perspectives to the table. This gives different answers to commonly debated issues such as unemployment, education or development. It also brings new youth specific issues and more progressive opinions in the established positions. One of these issues is sexuality.

The political youth leagues involved have integrated the SRHR issues in to their regular agenda. They have all approached parliamentarians from their respective parties, involved young parliamentarians in the network and organized activities within their organizations. Press coverage has so far included a debate article on abortion in Sweden's largest newspaper, signed by all network members, a debate article in another large newspaper by a representative from the conservative youth against George Bush's reinstatement of the Mexico City Policy, radio interviews with representatives from the network and more. The Social Democratic Youth made abortion and HIV/AIDS two of the main issues in their national human rights campaign run during the autumn of 2003. The campaign activists met over one hundred

thousand young students during the campaign and used web-based methods as well as articles in the larger national newspapers.

The success of this initiative in Sweden has led to expanding working with young decision-makers to other European countries in partnership with the IEPF-PD (Inter-European Parliamentary Forum on Population and Development). Our first European Young Decision-Makers meeting, in London, in December 2003, was very promising. Young decision-makers from Belarus, Denmark, Finland, Ireland, Portugal and the Netherlands joined us and provided the opportunity for exploring how the Swedish experience could inspire similar activism in other European countries. The Swedish experience where young people are welcomed in clinics and facilities specifically geared to their needs, combined with a 50-year history of comprehensive sexuality education, free and/or low cost contraceptives provided further opportunities for Europe's young decision-makers to work to improve sexual and reproductive health in their own countries as well.

Since then, these same young decision-makers have participated in international events around the tenth anniversary of the International Conference on Population and Development (ICPD) Programme of Action and engaged in national awareness raising activities. In order to work with young European decision-makers we can only say that we are very glad to be involved and are looking forward to sharing our experiences and learning from our European counterparts. This year, at the ten-year mark of ICPD, we can see how young people can actively contribute to the current activities to protect SRHR and look forward to its full implementation in the decade to come.

**Isabelle Sannestedt**  
[isabelle@agera.ssu.se],  
the Swedish Social Democrats  
Youth League

**Victor Bernhardt**  
[victor.bernhardt@rfsu.se],  
the Swedish Association for  
Sexuality Education (RFSU)



# ADOLESCENTS' REPRODUCTIVE HEALTH CARE

By Rebecca J. Cook and Bernard M. Dickens

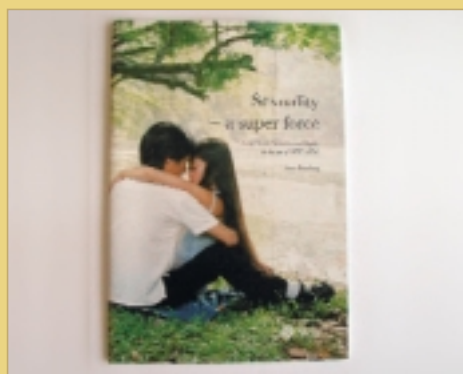


## The best thing is getting to know what others think...

A summary of a quality assessment of sex education in 80 Swedish schools.

By Agneta Nilsson and Birgitta Sandström

This National Agency of Education commissioned report shows that the quality of teaching varies not just between but also within schools. And the goal of integration matters related to sexuality and personal relationships in the teaching of various school subjects is still a long way off. Available from Liber Distribution [skolverket.lidi@liber.se].



## Young People, Sexuality and Rights in the era of HIV/AIDS

By Anna Runeborg

This Swedish International Development Cooperation Agency booklet from 2002 highlights the importance of frank and factual information on young people's sexuality. As one official put it: "What is worse, giving my daughters condoms while talking openly to them or facing their premature deaths?" Available from [www.sida.se](http://www.sida.se).

**The general health care of adolescents, who are widely understood to be people at or approaching their early teenage years to those in their early twenties, concerns health promotion, such as by encouraging a nutritious diet, proper exercise and continuing education.**

Regarding reproductive health care, however, the emphasis is more on preventive care, particularly facilitating protection against sexually transmitted infections (STI) and suffering or causing unplanned pregnancy. Risks grow as adolescents mature earlier and, particularly in Europe, marry later than in earlier times, and as looser family structures and less rigid social cultures leave adolescent girls more exposed to the sexual adventures, importuning, inducements and depredations of more mature men.

The exploitation of adolescent vulnerability always raises ethical and human rights concerns, but the law has been ambivalent in its protective role. It has at times supported parental over-protectiveness, maintaining adolescents in a condition of social infantilism that denies them the experience to gain mature self-protective judgment, and generating healthcare providers' fears that local laws restrict their capacity to give contraceptive and other reproductive health services to adolescents who come to them for care without parental consent. The burdens of enforced sexual innocence and denied contraceptive care fall more heavily on female than on male adolescents, although male vulnerability to STI should not be under-rated.

When adolescents marry, they become legally independent of their parents, and European laws now generally do not require wives to show their husbands' consent to their contraceptive and related care. More challenging are informal, unmarried unions, in which adolescents' legal status is unclear. Family laws may

analogize stable unions of two or so years' duration to legal marriage, but even so, partners' status in the intervening time may be ambivalent.

## Adolescents' "evolving capacities"

Some order has been introduced into the uncertainty regarding adolescents' independent access to healthcare and other services by the UN Convention on the Rights of the Child (the Children's Convention), ratified by all but a few countries of the world, such as Somalia and the U.S.A. The Convention defines a "child" as every human being below the age of 18 years unless, under the law applicable to the child, majority is attained earlier (Article 1). Majority could come at an earlier age, or by legal marriage, although the Convention applies to married persons aged under 18 years. The inference of the Convention is that persons aged 18 years and above rank generically as adults, and can make decisions for themselves, unless as individuals they suffer from an intellectual impairment.

Adolescents below the age of 18 (or earlier legal majority) may also be recognized, however, as sufficiently mature to take responsibility for exercise of their independent judgment, being what some legal systems describe as "mature minors." The Convention does not use this expression, but repeats the obligation to respect a child's "evolving capacities". Article 5 requires that:

"States parties shall respect the responsibilities, rights and duties of parents ... or other persons legally responsible for the child, to provide, *in a manner consistent with the evolving capacities of the child*, appropriate direction and guidance in the exercise by the child of the rights recognized in the present Convention" (emphasis added).

This makes clear that the rights are those of the child, and that parental guardians may provide, but not necessarily impose, direction and guidance.

Article 14 more emphatically provides that:

1. States parties shall respect the right of the child to freedom of thought, conscience and religion;
2. States parties shall respect the rights and duties of the parents, and, when

applicable, legal guardians, to provide direction to the child in the exercise of his or her right *in a manner consistent with the evolving capacities of the child* (emphasis added).

Article 14(1) has particular significance for reproductive healthcare, since “freedom of thought, conscience and religion” includes freedom to evaluate whether to observe religious restrictions on personal resort to methods of contraception, and abortion. Parents cannot veto their competent children’s access to medical procedures to which parents are opposed on grounds of conscience or religion. This is consistent with the judgment reached by the highest court in the U.K., in the influential Gillick case.

Adolescents’ capacities do not necessarily evolve at a uniform pace, so that adolescents who are capable of freely determining to be sexually active can also be able to decide that they are not yet ready to undertake the responsibilities of parenthood, but not able to exercise reliable judgment on resort to contraceptive sterilization or, for instance, to serve as surrogate or gestational mothers.

### Human rights

The Children’s Convention elaborates specific human rights of adolescents aged under 18 years, under international law and the national laws of ratifying countries, that build on human rights to which all human beings are entitled as an essential attribute of their human status and dignity. A right of infants and younger children incapable of sound judgment on their own behalf is to parental protection, provided by their parents or alternative legal guardians, underwritten by the state itself as a feature of state and governmental responsibility. In this sense, dependent children are entitled to paternalism, better described in gender-neutral terms as parentalism. However, adolescence is a stage of transition from dependent childhood to independent adulthood, when young people may believe that they have acquired capacities that they have not yet adequately achieved, but also when adults, particularly the parents who have reared them from infancy, are liable to deny that they have acquired the maturity and responsibility they actually possess. Parents’ benign instincts to protect their children can degenerate into posses-

sive over-protectiveness, and denial that their children are maturing social beings in their own rights.

In June 2003, the Committee on the Rights of the Child, established under the Children’s Convention to monitor and guide parties’ compliance with its provisions, issued its General Comment No. 4 on Adolescent Health and Development to address the Committee’s Concern “that in implementing their obligations under the Convention, States Parties have given insufficient attention to the specificities of adolescents as rights holders and to the promotion of their health and development” (para. 3). While considering adolescents’ human rights in general, the General Comment at points addresses reproductive and sexual health rights in particular.

For instance, the right to non-discrimination is explained to cover adolescents’ sexual orientation and HIV/AIDS health status. A facet of discrimination obviously concern age, but another concerns sex. Adolescent girls and young women often require doctors’ prescriptions for contraceptive products, while males’ access to condoms is not subject to this scrutiny or expense. Healthcare providers are frequently restrictive about seeming to promote sexual activity of adolescent females when they do not bear any responsibility for that of males, with whose sexuality they are usually less involved. They may be fearful of parental condemnation, especially among communities in which female virginity is an important aspect of family honour and status, and of violation of applicable laws.

However, addressing legal and judicial measures, the General Comment requires that:

“In the context of the rights of adolescents to health and development, States parties need to ensure that specific legal provisions are guaranteed under domestic law, including with regard to setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent. These minimum ages should be non-discriminatory between boys and girls and closely reflect the recognition of . . . their evolving capacity, age, and maturity” (para. 6(d))

Accordingly, national legislation should incorporate the “mature minor”

rule for adolescents not of majority age, and courts should interpret and apply national law consistently with this rule. Medical confidentiality is often critical to adolescents availing themselves of protection against pregnancy and STI. The General Comment builds on several articles of the Children’s Convention to note that:

“Health care providers have the obligation to ensure confidentiality of medical information of adolescents, in light of the principles of non-discrimination, best interests of the child, right to life, survival and development and the right to express its views freely in all matters . . . Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment” (para. 6(e)).

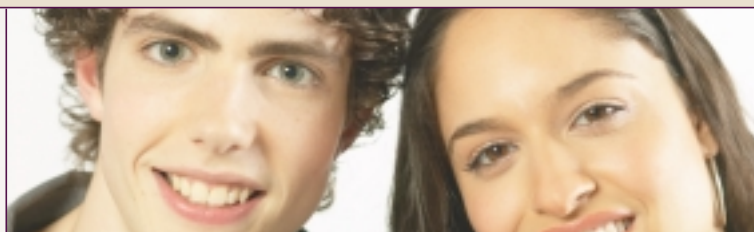
Regarding rights to health-related information and services, the General Comment identifies Convention Articles that address rights “such as family planning . . . [and] protection from harmful traditional practices, including early marriage and female genital mutilation” (ibid). The last item has become familiar in Europe in recent years largely through immigration from regions where the practice of female genital cutting has been traditional.

Paragraph 21 brings together several Convention Articles and its own earlier discussion to conclude that “States Parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of STIs.” Information must include reasonable access to services. For instance, paragraph 23 provides that:

“Adolescents, both girls and boys, are at risk of being infected with and affected by sexually transmitted infections, including HIV/AIDS. States should ensure that appropriate goods, services and information for the prevention and treatment of STI, including HIV/AIDS, are available and accessible.”

Concerning girls, paragraph 24 explains that:

“those who become pregnant should



have access to health services that are sensitive to their particularities and rights. States Parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly due to early pregnancy and unsafe abortion practices . . . The Committee urges States Parties to . . . develop and implement programmes that ensure access to sexual and reproductive health services, including family planning, contraceptive methods and safe abortion services in circumstances where abortion is not against the law, adequate comprehensive obstetric care and counseling.”

Given divergent national approaches to abortion, the Committee may have been reluctant to seem to direct countries ratifying the Children’s Convention to reconsider their restrictive abortion laws, in the same way that the World Health Organization (WHO) refrained from directly recommending this in its 2003 publication *Safe Abortion: Technical and Policy Guidance for Health Systems*. Without calling for change, however, the WHO publication made it clear that restrictive laws and policies are a major contributing cause of unsafe abortion, and that adolescent girls are at particular disadvantage and risk in navigating a path through obstacles in the way of access to lawful services. Legal provisions on parental consent, and fear that their confidentiality will not be respected, deter many pregnant adolescents from access to care lawfully available to them in theory, and induce their resort to unskilled practitioners, including attempts at self-termination of pregnancy. The WHO guidance helpfully establishes, however, that emergency or post-coital contraception, undertaken within 72 hours of unprotected intercourse, is properly regarded as contraception. It is not termination of pregnancy since, if pregnancy has begun, emergency contraceptive treatment will have no effect. The WHO guidance and the Committee’s General Comment echo legally binding international treaties that protect adolescents’ rights to life, to the highest attainable standard of health and, for instance, to liberty and security of the person, education and information.

Security has been a long-standing concern of the Committee on the Rights of the Child. It has often discussed violence

against children, including the need for protection and strategies against sexual violence, which its General Comment addresses in a section on protection from all forms of abuse, neglect, violence, and exploitation. Paragraph 6(f) goes beyond sexual violence, to include more subtle ways of taking sexual advantage of children and adolescents and exploiting their vulnerability. The Committee observes how homelessness, substance addiction and, for instance, poverty can condition adolescents to exchange sexual availability for shelter, drugs, money, and satisfaction of other needs and wants.

### HIV/AIDS

Adolescents’ risk of exposure to HIV infection, among many other items addressed in the Committee’s General Comment No. 4, is the sole concern of its General Comment No. 3, also of 2004, entitled HIV/AIDS and the rights of the child. This considers children’s and adolescents’ vulnerabilities to HIV/AIDS comprehensively, as infected persons and as children and other dependents of infected adults. It places their risk, however, primarily in the context of their sexuality and reproductive health. It reminds states that:

“children require relevant, appropriate and timely information which recognizes the differences in levels of understanding among them, is tailored appropriately to age level and capacity and enables them to deal positively and responsibly with their sexuality in order to protect themselves from HIV infection . . . [E]ffective HIV/AIDS prevention requires States to refrain from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, and . . . states parties must ensure children have the ability to acquire the knowledge and skills to protect themselves and others as they begin to express their sexuality” (para. 13).

Paragraph 17 of General Comment No. 3 encourages parties to the Children’s Convention to employ trained personnel to offer children

“access to HIV-related information, voluntary counselling and testing, knowledge of their HIV status, confidential sexual and reproductive health services, free or low cost contraception, condoms and services, as well as

HIV-related care and treatment if and when needed.”

Paragraph 33 anticipates a point made more generally in General Comment No. 4 in noting that :

“Girls and boys who are deprived of the means of survival and development, particularly children orphaned by AIDS, may be subjected to sexual and economic exploitation in a variety of forms, including the exchange of sexual services or hazardous work for money to survive, support their sick or dying parents and younger siblings, or to pay for school fees.”

States are required to protect all children from sexual exploitation and falling prey to prostitution networks, trafficking and sale.

The Comment identifies further circumstances in which children, particularly those approaching sexual maturity, may be at sexual and reproductive health risk, including by rape and other sexual abuses in family or foster settings, schools, prisons, mental health institutions and those for disabled children. It notes vulnerability in the context of war and armed conflict, including when adolescents are “used by military or other uniformed personnel to provide domestic help or sexual services” (para. 34), or are internally displaced or living in refugee camps. Through the lens of vulnerability to adolescents’ sexual and reproductive health, the Committee focuses on a wide range of threats to adolescents’ sexual and reproductive health, which it places in a wider human rights framework through its General Comments Nos. 3 and 4. The evidence and experiences on which these Comments are based underline the urgency of international action to apply and strengthen human rights principles in defence of the sexual integrity and reproductive health of the most exploitable, most easily disregarded and least well-represented members of our communities.

**Rebecca J. Cook**  
[rebecca.cook@utoronto.ca]  
**Bernard M. Dickens**  
[bernard.dickens@utoronto.ca]

Faculty of Law, Faculty of Medicine  
and Joint Centre for Bioethics,  
University of Toronto, Canada



# YOUTH FRIENDLY SERVICES, ADDRESSING DIVERSITY

Upeka de Silva

## Do you think that a young homosexual man from an ethnic minority will find your sexual and reproductive health services accessible?

If you are committed to providing youth friendly services which respect, protect and fulfil the sexual and reproductive health rights of young people, then he should!

In some circumstances this may seem a tall order and there is no single answer and no single approach, but there are a few core elements which need to be in place to ensure the provision of rights-based youth friendly services and these shall be briefly explored below.

Adolescent sexual and reproductive health is one of the five principal priorities within the new strategic direction of the International Planned Parenthood Federation (IPPF) and initiatives within this strategic framework are to be informed by five crosscutting themes: rights, diversity, vulnerability, quality and youth participation.

Before examining these elements of service delivery, it is essential that we scrutinize why we consider youth friendly services important. If we believe that young people's sexual and reproductive health needs are not restricted to concerns relating to the reproductive system and that it plays a significant role in the overall development and wellbeing of a young person, then the desired goal of providing holistic services can be reached. For example, if we are able to sensitize young people about the diversity of individual sexuality and the importance of bodily integrity, crimes committed based on homophobia are likely to be reduced. However, this is not to say that youth friendly services should be provided to fight crime, but it is to illustrate that our services should be based on the recognition that sexuality is a fundamental part of human nature.

### Rights, diversity and vulnerability

Respecting, protecting and fulfilling the sexual and reproductive health rights of young people and accepting young people

as sexual beings form the basis of any initiative on youth friendly services. Commitment to rights and thereby the principle of non-discrimination means that these services need to reach and be accessible to a diverse group of young people. In light of this, we need to understand diversity not only in terms of those in school or out of school and their socio-economic status (e.g. street children and refugees) but also in terms of their sexuality, HIV status and differing cultural contexts and its implications (e.g. female genital mutilation and early marriage). There is also a need to look beyond traditional "groups" of young people, such as sex workers or street children as there are differences within these groups which might be overlooked and because categorizing them in this way can in itself be stigmatizing.

The sheer numbers to be considered is indeed a great challenge for resource poor SRH facilities. It is therefore believed that focusing on vulnerability within the diverse groups could perhaps enable providers to reach those young people whose sexual and reproductive health rights are most violated. So, what is vulnerability and how can service providers identify those most vulnerable?

Vulnerability as a result of the violation of fundamental human rights is one way of understanding the term. Sexism, racism and hetero-sexism all contribute to social exclusion and vulnerability. In addition to discrimination, the violation of the right to information, services, privacy, confidentiality and freedom from abuse and exploitation significantly impact upon a young person's vulnerability to sexual and reproductive ill health.

On the other hand, but closely linked to individual integrity and respect, it could be said that feelings of low self-esteem, worthlessness and a hopelessness about their future can also cause young people to become vulnerable as they are often reluctant to seek health services and do not see safer sexual practices or general healthy behaviour as a priority. Another key factor, especially relevant to service providers, is that their socio-economic circumstances have caused many of these young people to lose faith and trust in adults, and recognizing this can help to ensure that initiatives respond to

the realities of these young peoples' lives.

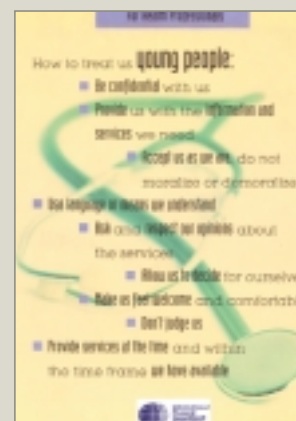
In the light of these arguments, examining innovative ways in which to address the needs and rights of the poor and rural populations, gay and lesbian young people, those living with HIV, and survivors of sexual coercion could be a step in the right direction to reaching the underserved and invisible groups of young people.

### Quality

Having identified the potential beneficiaries of SRH services, attention needs to be placed on understanding what it is that makes a service youth friendly and respectful of young people's SRH rights.

It is perhaps worthwhile questioning the difference between services provided for young people and those provided for adults. On the face of it, principles of confidentiality, affordability, accessibility and the participation of stakeholders are equally important. Yet, due to their limited physical mobility and financial resources, the location, opening hours and cost of services for young people need special consideration.

One of the key elements of youth friendliness is the providers' attitude. Youth friendliness requires that providers are respectful and non-judgemental and this becomes all the more important when dealing with vulnerable young people with whom a trusting non-patronising relationship needs to be developed. Exploring attitudes and clarifying values of staff and service providers is crucial for ensuring that they are confident and comfortable about providing sexual and reproductive health services to young people and that young people are treated with respect.

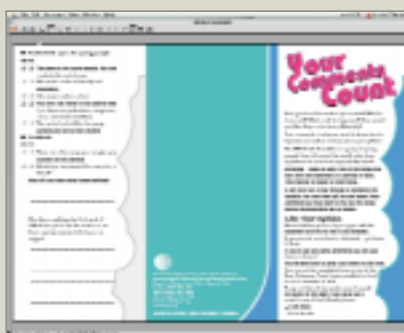


The Youth Committee of IPPF developed a poster which set out some of the key components of a youth friendly service.



In addition to how the services are provided, attention should also be placed on what services are provided, in order to uphold the sexual and reproductive health rights of young people. Every effort needs to be made to provide a comprehensive array of information and services, enabling the young clients to make informed decisions. Some services which are often neglected are safe abortion and related services, services for survivors of sexual abuse or coercion, services for those living with HIV/AIDS, emergency contraception and voluntary counselling and testing (VCT) for sexually transmitted infections including HIV.

It is important to note that the provision of emergency contraception and VCT services, in particular, provide a good entry point for talking about general sexual and reproductive health issues with young people, and service providers should take every opportunity to explore these issues with their clients.



[The IPPF Youth Committee prepared a checklist on youth friendly services which can be used as a client exit survey and an evaluation tool – [www.ippf.org/youth/pdf/english\\_leaflet.pdf](http://www.ippf.org/youth/pdf/english_leaflet.pdf)]

It is accepted that many service centres are often unable to provide all these services, and this is where establishing partnerships and referral agreements with other service providers becomes vital.

## Enabling environment

It has been observed that improving the quality of the clinic can overcome at least some barriers that inhibit young people from accessing sexual and reproductive health services. However, we are now learning that the increased uptake of reproductive health services by youth is much more stimulated by community acceptance of young people being sexually active than making services more youth friendly. In other words, new and

innovative approaches can not be successful without a strong commitment from the community to accepting young people as sexual beings.

Therefore, youth friendly service provision needs to be accompanied by community sensitization and mobilization to secure community support, thereby making the services accessible to young people.

## Youth participation

In order to achieve all the aforementioned goals, there is one critical component which IPPF strongly believes in, and that is youth participation. This is based on the conviction that young people have the right to participate in decisions that affect their lives and that a youth adult partnership in decision-making enables more effective and realistic initiatives to be adopted.

## Conclusion – Moving from the rhetoric to reality

The above-mentioned concepts might seem rather rhetorical and I would like to take this opportunity to submit that the essence of a rights-based approach to youth friendly services is an organizational ethos in which everyone from the doctor to the receptionist embraces the underpinning values of equality and diversity and incorporates it in their daily practices. For example, this requires that they ask themselves, not only “who are we serving” but “who are we not serving and why” – is it the young migrant girl? Is it because the clinic has an all white staff and none of the information resources are in her language?

It is also about making a conscious effort to avoid stereotypical assumptions about the young people who come through their door; for instance, we should not assume heterosexuality and we should not assume that a young person with a disability will automatically be meek, vulnerable or asexual.

There is an urgent need for all of us who are passionate about upholding the sexual and reproductive health rights of young people to rethink our approach to service provision and identify innovative means of achieving an environment in which young people are respected and accepted as sexual beings, are able to access comprehensive sexual and repro-

ductive health services regardless of their, inter alia, age, sex, sexual orientation or marital or HIV status and thereby make informed choices about their sexual and reproductive lives.

## Further reading

- Going for Gold – A clinic guide to the National Adolescent Friendly Clinic Initiative – NAFCI/ Love life - South Africa 2000
- Adolescent Friendly Health Services – An Agenda for Change. WHO 2003 [www.who.int/reproductivehealth/publications/cah\\_docs/cah\\_02\\_14.html](http://www.who.int/reproductivehealth/publications/cah_docs/cah_02_14.html)
- Do youth friendly services make a difference? – In Focus. December 1997 [www.fhi.org/en/Youth/Youthnet/Publications/FOCUS/InFOCUS/index.htm](http://www.fhi.org/en/Youth/Youthnet/Publications/FOCUS/InFOCUS/index.htm)
- Making reproductive health services youth friendly – Focus on Young Adults 1999 [www.pathfind.org/focus.htm](http://www.pathfind.org/focus.htm)
- Youth friendly services – a manual for service providers. Engender Health 2002 [www.engenderhealth.org](http://www.engenderhealth.org)

**Upeka de Silva**  
[[UdeSilva@ippf.org](mailto:UdeSilva@ippf.org)]  
Junior Professional Officer  
International Planned Parenthood Federation

# SEX DOES NOT HAVE TO BE DANGEROUS TO YOUR HEALTH

by Dr Paul Van Look and Rebecca Harding

**How many people associate sexual and reproductive health with a global crisis? Too few, judging by the action – or inaction – of individuals and their governments.**

The evening news is full of stories about SARS or the hazards of smoking, but how many people realize that the second biggest risk to your health is unsafe sex (1)? Or that, just last year, three million adults and children died of HIV/AIDS (2)? Or that a quarter of a million women died of cervical cancer (3)? Or that half a million women died during pregnancy and childbirth (4)? Or that millions of men and women suffered from sexually transmitted infections causing sickness, infertility and other conditions? The reality is that improving our sexual and reproductive health is at least as important as any other health challenge facing us today. It touches the lives of everyone, everywhere and throughout every stage of life. It is fundamental to the social and economic development of our communities, economies and nations. It reflects – and reinforces – some of the most basic inequalities in our societies, the inequalities of wealth and of gender. And, most important, it is solvable.

Sexual and reproductive health is an area where real and dramatic improvements are within reach. In 2004 there is simply no excuse for allowing women to die in childbirth; people can be taught to practise safe sex; family planning can work even in the poorest and most remote countries. And yet for some reason, the issue is not on our collective radar screen. The problem is not that we lack the resources or the expertise; the problem is that we are failing to act. The World Health Organization (WHO) is determined to change that.

## **What are the main obstacles to progress?**

The first is common to almost all global health challenges: poverty. The reality is that the burden of sexual and reproductive ill-health is greatest in the poorest

countries, where access to information, basic sanitation and even food can be limited, and where health services tend to be scattered, poorly staffed, poorly equipped and beyond the reach of most people. Most maternal deaths, for instance, arise from complications during childbirth; but poorer countries often lack skilled birth attendants, crucial medicines, and emergency facilities to deal with these complications. In the same way, HIV/AIDS is made more lethal in poorer countries because it often goes undiagnosed, because competent, affordable services are lacking, and because access to life-saving treatment is unavailable. And yet experience has shown that, even in low-income countries, innovative country-specific approaches can achieve significant improvements.

There is a second obstacle to progress in sexual and reproductive health in many countries that may be less visible than poverty but no less insidious: discrimination against women. These inequalities can be stark, with huge implications for sexual and reproductive health. Families may invest less in nutrition, health care, schooling and vocational training for girls than for boys. The lower status of girls and women can be manifest in sexual abuse, poor physical and mental health, and pervasive lack of control over their lives, particularly their sexual and reproductive lives. In some countries, nearly one in four women experience rape, violence and other forms of sexual abuse by a partner (5). And the trafficking of women and children and forced prostitution has devastating consequences, including unwanted pregnancies, unsafe abortions, chronic pain syndromes, sexually transmitted infections, including HIV, and gynaecological disorders, not to mention the huge damage to women's psychological and emotional health.

The third obstacle is perhaps the biggest, in some sense reinforcing the others – many people's inability to make choices about – and to take ownership of – their sexual and reproductive health due to illiteracy, lack of access to education or medical advice, and barriers erected to prevent people from learning about sexual and reproductive health. About 80 million women every year have unintended or unwanted pregnancies,

partly because many have an unmet need for family planning and contraception. Some 45 million pregnancies are terminated each year, of which an estimated 19 million end in unsafe abortions, killing 68,000 women every year (6). Of the estimated 340 million new cases of sexually transmitted bacterial infections each year (7) – plus millions more viral infections, including five million new HIV infections (8) – practically all were preventable through safe-sex practices. Over the past two decades, major advances have been made in our knowledge of sexual and reproductive health – in family planning, in halting the spread of sexually transmitted infection, in safer pregnancies, in life-saving technologies in reproductive health, and in successfully treating infertility, to name just a few. Yet in too many countries this information is not getting to the people who most need it. Taboos and norms about sexuality pose strong barriers to providing information, reproductive health services and other forms of support that men and women need to be healthy. In some countries, laws, policies and regulations actually stand in the way of access to services (e.g. excluding unmarried people from contraception), unnecessarily limiting the roles of health personnel (e.g. preventing midwives from performing certain life-saving procedures), barring the provision of some services (e.g. over-the-counter provision of emergency contraception), or restricting the importation of essential drugs and technologies.

## **What can WHO and its Member States do?**

Concerned about the slow progress made in improving sexual and reproductive health over the past decade, and knowing that the Millennium Development Goals (MDGs) would not be achieved without refocused and renewed commitment by the international community, the 2002 World Health Assembly charged the WHO Secretariat with devising a strategy for translating global goals and objectives into global action. Developed through a process of intensive consultation with countries and other partners from all six WHO regions, the resulting strategy paper, which was adopted by the 57th World Health Assembly in May this year, targets five priority aspects of sexual and



reproductive health: 1. improving antenatal, perinatal, postpartum and newborn care; 2. providing high-quality services for family planning, including infertility services; 3. eliminating unsafe abortion; 4. combating sexually transmitted infections, including HIV, reproductive tract infections, cervical cancer and other gynaecological morbidities; and 5. promoting sexual health.

Because of the close linkages between the different aspects of sexual and reproductive health, interventions in one area are likely to have a positive impact on the others. It is therefore critical for countries to strengthen existing services and infrastructure, and to use them as entry points to develop new interventions, looking to maximize synergies and avoid duplication of scarce resources. The strategy proposes five overarching areas for action:

- strengthening health systems capacity;
- improving information for priority setting;
- mobilizing political will;
- creating supportive legislative and regulatory frameworks; and
- strengthening monitoring, evaluation and accountability.

Underpinning this strategy is a fundamental commitment to human rights: the right of all persons to the highest available standard of health care; the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so; the right of women to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence; the right of men and women to choose a spouse and to enter into marriage only with their free and full consent; the right of access to relevant health information and the right of everyone to enjoy the benefits of scientific progress and its applications. To ensure that these rights are respected, policies, programmes and interventions must promote gender equity, give priority attention to the poor and underserved populations and population groups, and provide special support to those countries that bear the largest burden of sexual and reproductive ill-health.

In short, we have clear objectives, we have the resources and expertise, and we have a plan. What is needed is the political will to act. Too often in today's international system there is a gulf between global commitments and global realities. Nowhere is this discrepancy more obvious than in the area of sexual and reproductive health. We know that three of the United Nation's eight MDGs set out ambitious targets for the year 2015 in this very area: reducing the maternal mortality ratio by three quarters; reducing child mortality by two thirds; and halting, then reversing, the spread of HIV/AIDS. Yet, today, just as many women are dying in pregnancy and childbirth as they did a decade ago. And the spread of HIV/AIDS is accelerating, and not diminishing, in many areas of the world. This has to change. Sexual and reproductive health should be about love, life and relationships, not sickness and death. We owe it to ourselves, to our partners and to our children to begin delivering on these promises now.

## References

1. The World Health Report 2002. World Health Organization, Geneva (2002) Annex Table 13, pp.230-232
2. AIDS epidemic update 2003, Joint United nations Programme on HIV/AIDS (UNAIDS/03.39E) and World Health Organization, Geneva, (2003)
3. The World Health Report 2002. World Health Organization, Geneva (2002) Annex Table 2, pp.186-191.
4. Carla Abou Zahr and Tessa Wardlaw, "Maternal mortality in 2000: Estimates developed by WHO. UNICEF and UNFPA," (2003), p. 3.
5. World report on Violence and Health. World Health Organization, Geneva, 2002, p.89
6. *Safe Abortion: Technical and Policy Guidance for Health Systems*. World Health Organisation, Geneva, (2003), pp.12-16.
7. Global prevalence and incidence of selected curable sexually transmitted diseases: overview and estimates. World Health Organization, Geneva (2001).
8. AIDS epidemic update 2003, Joint United nations Programme on HIV/AIDS (UNAIDS/03.39E) and World Health Organization, Geneva, (2003), p.3.

**Excerpts dealing with young people's health from WHO's first global strategy on reproductive health. The full strategy is available at: [www.who.int/reproductive-health/](http://www.who.int/reproductive-health/)**

### *Adolescents' exposure to risk*

25. In most countries, taboos and norms about sexuality (including practices such as child marriage, female genital mutilation and early sexual initiation) pose strong barriers to providing information, reproductive health services and other forms of support that young people need to be healthy. Yet, sexual and reproductive behaviours during adolescence (ages 10 to 19) have immediate and long-term consequences. In some parts of the world, sexual activity begins during adolescence, and is often risky, whether within or outside marriage. Adolescents rarely have the ability or support to resist pressure to have sexual relations, negotiate safer sex, or protect themselves against unintended pregnancy and sexually transmitted infections. For very young girls, pregnancy carries a high risk of maternal mortality and morbidity. Meeting the needs and protecting the rights of the 1200 million adolescents worldwide are essential to safeguard the health of this and future generations.

### *Strengthening health systems capacity*

50. Use of services. Where health services exist, there are many reasons – social, economic and cultural – why people nevertheless do not use them, particularly in relation to reproductive and sexual health. Identifying and overcoming obstacles require working with women, young people, and other community groups to understand better their needs, analyse problems and find acceptable solutions.

**Dr Paul Van Look**  
(Director) and

**Rebecca Harding**  
(Communications Officer)  
[hardingr@who.int]  
Department of Reproductive  
Health and Research  
WHO, Geneva, Switzerland

# SEXUAL HEALTH IN YOUNG PEOPLE – FINDINGS FROM THE HBSC STUDY

*Jim Ross, Emmanuelle Godeau and Sonia Dias*

The following article is an extract from the Health Behaviour in School-Aged Children (HBSC) report recently published by the WHO Regional Office for Europe (1).

Sexual health is a substantial part of adolescents' general, social and personal well-being (2). One of the primary developmental aspects of adolescence is the consolidation of identity in general, and sexual identity in particular. The development of sexuality in adolescence involves physical changes associated with puberty, psychological changes and interpersonal events. Adolescents need to learn how to be comfortable with themselves, how to deal with their sexual feelings and how to relate in a healthy way to other people.

Adolescence is both a period of opportunity, when new options and ideas are explored, and a time of vulnerability and risk. Fortunately, most adolescents emerge from these changes with positive outcomes. Nevertheless, some of the behaviour associated with adolescence – spontaneity, social immaturity, risk taking and volatility – may affect many issues relating to sexual health.

The key public health concerns around teenage sexual health include pregnancy and sexually transmitted infections (STI). These cause significant health, social and economic problems among young people, and are largely preventable through the coordinated efforts of families, schools, health and education agencies, and community organizations. The development of effective, school- and community-based programmes depends in part on gaining information about the nature and extent of sexual behaviour among adolescents. Current information on issues related to young people's sexual health is urgently needed to help develop policies and programmes. A better understanding is needed of the social and cultural determinants of sexual risk taking, as well as corresponding protective factors, so that interventions can both be comprehensive and effectively targeted.

Few cross-national data have been available about the sexual health of adolescents. For this reason the 2001/02 survey of the Health Behaviour in School-aged Children (HBSC) study included, for the first time, questions on sexual health designed for use for 15 year olds. The HBSC study, established 22 years ago, is cross-national research conducted by an international network of research teams in collaboration with the WHO Regional Office for Europe. Its aim is to gain new insight into and to increase understanding of young people's health, well-being, health behaviour and social context.

Surveys are carried out every four years on national samples of children attending school aged 11, 13 and 15 years using a standardized international questionnaire. The average sample size in each participating country is 4500 children (all age groups). In the 2001/02 HBSC survey 35 countries and regions participated, although not all of them were able to include the questions on sexual health in their national questionnaires, primarily on the grounds that doing so would most likely have a negative impact on school participation rates.

## Methods

The questions on sexual health were adopted from the US Youth Risk Behavior Survey (YRBS) (3) and are known to have produced reliable data in the United States (4,5). Only the 15-year-olds surveyed were asked to respond to the sexual health items, because the overwhelming majority of younger adolescents have not yet experienced sexual intercourse and such questions are considered too sensitive for the younger age groups. Four items were used:

1. Have you ever had sexual intercourse? (Sometimes this is called "making love", "having sex", or "going all the way".) The response options were: Yes, No.
2. How old were you when you had sexual intercourse for the first time? The response options were: I have never had sexual intercourse, 11 years or younger, 12 years old, 13 years old, 14 years old, 15 years old. [Data not presented here]
3. The last time you had sexual intercourse, did you or your partner use a condom? The response options were: I

have never had sexual intercourse, Yes, No.

4. The last time you had sexual intercourse, what method(s) did you or your partner use to prevent pregnancy? The response options were: I have never had sexual intercourse; No method was used to prevent pregnancy; Birth control pills; Condoms; Spermicidal spray or foam; Withdrawal; [National choice option – questionnaires could include additional country- or region-specific options where desired]; Some other method; Not sure.

The first question includes cues to assist the young person to understand the meaning of the term sexual intercourse. Validity studies have shown that such self-reports are accurate (6) and that most young people interpret the cues as indicative of vaginal intercourse. The risk of contracting an STI through other forms of sexual behaviour is therefore not captured. Another limitation of the data is that, by asking only whether young people had ever had sexual intercourse, the question did not identify those who were currently sexually active and therefore at risk of pregnancy and STI.

Age at first sexual intercourse was investigated because early first intercourse is thought to be linked to unplanned, unprotected sex and therefore to a greater risk of unintended pregnancy and STI. Moreover, early first intercourse correlates with other modes of risk taking. Alcohol and drug use have a clear association with early first intercourse, which is likely to be unintended and unprotected (7–9).

Research has shown that adolescents have difficulty in summarizing their use of contraceptives, even for short time periods, because their use is not consistent (10). Adolescents may use condoms, contraceptive pills or other methods sporadically, depending on the situation and the sexual partner. In addition, if asked about typical behaviour, respondents (both adults and young people) are more likely to bias their answers by describing socially desirable behaviour. Responses about the last encounter have higher reliability and validity than those on typical behaviour. In the analyses of the data reported in response to these two ques-



tions, young people who responded to either question by saying that they or their partners used a condom during the last intercourse were regarded analytically as having used a condom in both cases: that is, to prevent both pregnancy and transmission of STI.

For these analyses, responses to the fourth question were combined to provide a summary measure of the proportion of 15-year-olds reporting use of at least one mode of contraception. The pre-coded response for withdrawal was excluded because this method offers little or no protection from pregnancy. National choice options and other write-in responses were included. Future analyses of the data on the use of condoms and other means of contraception will pay particular attention to such responses.

A further question on age at first intercourse was also included (not shown here). The mean age across all countries and regions is 14.3 years for girls and 14.0 for boys. The mean age ranges from 13.5 years in Lithuania to 14.6 years in Ukraine. In most countries and regions, it is slightly lower for boys than for girls. The largest gender difference, about one year, is found in Portugal.

## Results

The four sexual health questions allow the investigation of four research questions.

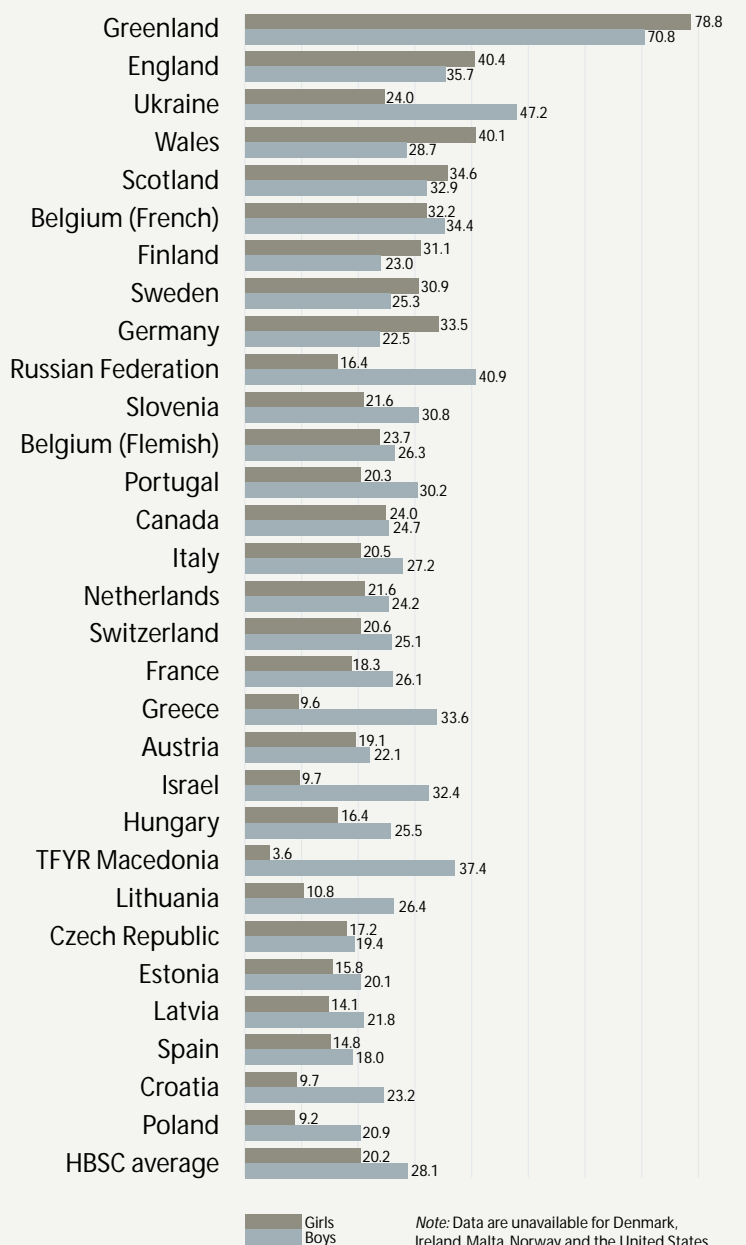
- What proportion of the population has experienced sexual intercourse?
- What proportion of the sexually active population experienced early intercourse?
- How many in the sexually active population protect themselves and their partners by using condoms?
- How many in the sexually active population protect themselves and their partners against pregnancy by using some type of contraception?

As mentioned, for these analyses, responses to the question on contraceptive methods were combined to provide a summary measure.

## Experience of sexual intercourse

Thirty of the countries and regions included in this analysis asked 15-year-olds whether they had ever had sexual intercourse. The differences in responses are striking (Fig. 1). The percentages of

Fig. 1 Young people who have had sexual intercourse, 15-year-olds (%)



15-year-olds who report having had sexual intercourse range from 15% in Poland to 75% in Greenland. In nine countries and regions, mainly in eastern and central Europe, plus Spain, fewer than a fifth of young people report ever having had sexual intercourse. At the upper end of the spectrum, in England, Greenland, Scotland, Ukraine and Wales, a third or more have had sexual intercourse.

The gender differences are wide. Among boys, positive responses range from 18% in Spain to 71% in Greenland. The Czech Republic, Estonia, Poland and Spain cluster at the low end with rates of about 20%. At the opposite end of the spectrum, in nine countries and regions, about a third or more of boys have had sexual intercourse. Among girls, positive responses ranged from 4% in the former Yugoslav Republic of Macedonia to 79%

in Greenland. Rates are below 20% in 15 countries and regions but about 33% or more in 6 others.

Interestingly, in the latter group, more girls than boys declared having had sexual intercourse. The largest differences are found in Germany and Wales. In eight countries, a more traditional pattern prevails with at least twice as many boys as girls having had sexual intercourse. Over three times as many boys as girls gave positive answers in Greece and Israel, and over ten times as many in the former Yugoslav Republic of Macedonia.

### Use of condoms

The proportion of sexually active young people who report using a condom the last time they had sexual intercourse ranges from 64% in Finland to 89% in Greece (Fig. 2). The proportions are 70%

or less in six countries and regions, with Finland and Sweden at the low end, and 80% to nearly 90% in seven others, with the highest levels in Greece and Spain.

In almost all countries and regions, boys are more likely than girls to report condom use the last time they had sexual intercourse. The gender difference can sometimes be quite large, as in Belgium (Flemish) and Ukraine. The proportions reporting condom use ranges from 68.5% in Portugal to 91% in Greece for boys, and from 58% in Sweden to 89% in Spain for girls.

### Use of contraception

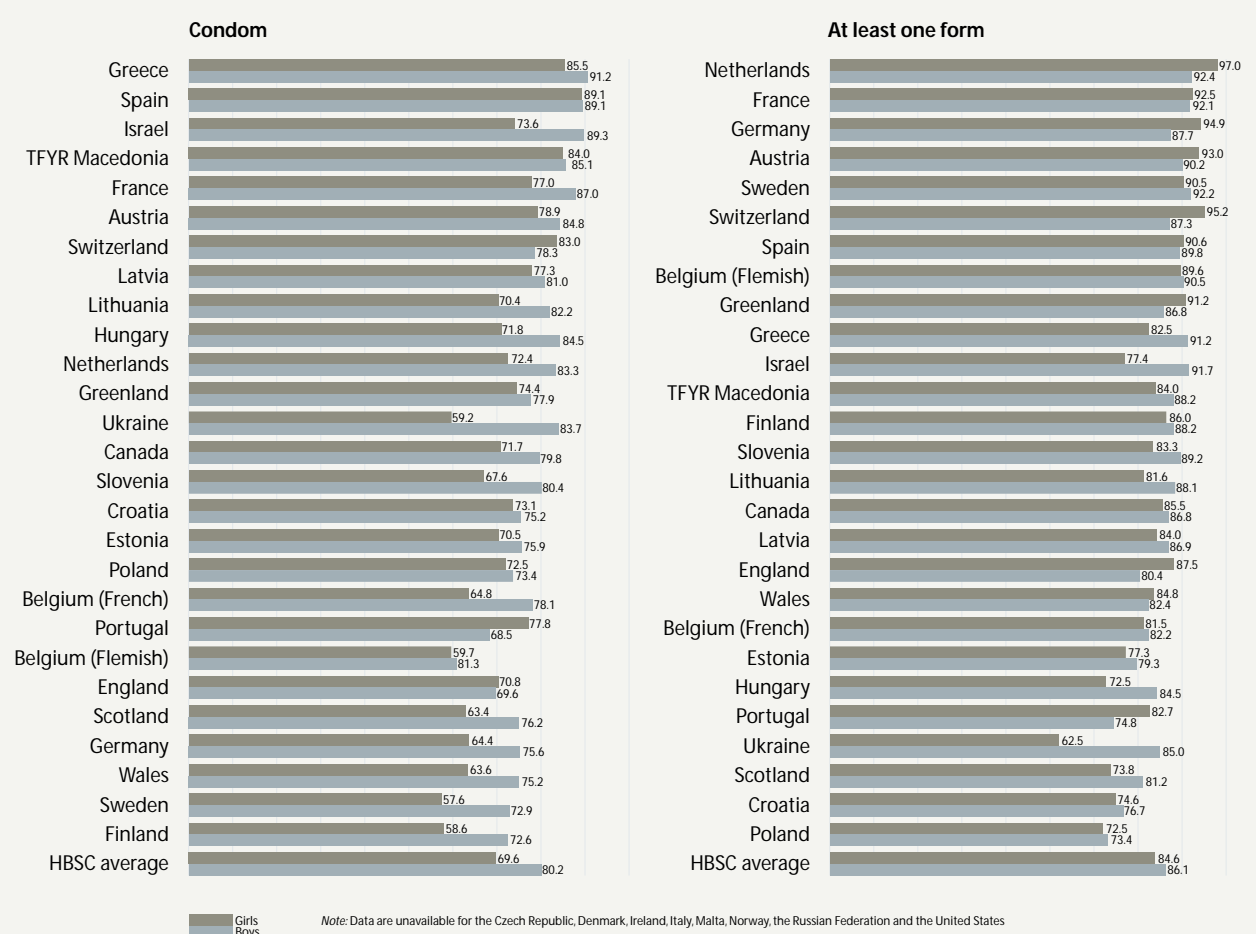
The proportions of sexually active young people reporting the use of at least one method of contraception (including but not limited to condoms and birth control pills) during their most recent inter-

course ranges from 73% in Poland to 95% in the Netherlands (Fig. 2).

Proportions are below 80% in seven countries and at or above 90% in eight others.

The proportions reporting use of contraception range from 73% in Poland to 92% in the Netherlands for boys and from 68% in Ukraine to 97% in the Netherlands for girls. The countries and regions are almost evenly split as to whether boys or girls have a higher rate of contraception use; in many, the gender rates are nearly identical. Boys are far more likely than girls to use contraceptives in Greece, Hungary, Israel and Ukraine. Girls are more likely to use contraceptives in England, Germany, Greenland, Portugal and Switzerland.

Fig. 2 Young people who used contraception during their last sexual intercourse, 15-year-olds (%)





## Discussion

The responses to the four questions relating to sexual health demonstrate noteworthy differences across the HBSC countries and regions in the proportions of 15-year-olds having had sexual intercourse, the mean age at first intercourse and the use of contraceptives during the most recent intercourse. Cross-national differences undoubtedly reflect fundamental cultural, social, religious and educational differences across countries, as well as differences in public policy. The most important findings demonstrate variations across countries and regions in the use of condoms. While no more than 70% of sexually active young people used a condom the last time they had sexual intercourse in six countries, 80–90% of sexually active young people did so in seven others. These findings have important policy implications. In the context of HBSC, however, further analysis will give an opportunity to explore the determinants of condom use within and across countries in relation to other risk behaviours (especially drug and alcohol use), school and community bonding, school performance and parental relations.

Examination of the gender differences shows that, in many countries and regions, the traditional expectations tied to gender are eroding. For example, while boys are twice as likely as girls to have experienced sexual intercourse in nearly a third of HBSC countries and regions, the genders are almost equal in this experience in many more, and girls are more likely than boys to have experienced intercourse in six (England, Finland, Germany, Greenland, Scotland and Wales). In almost all countries and regions, boys are more likely than girls to report that a condom was used during their last intercourse. The gender difference can sometimes be quite large, as in Belgium (Flemish) and Ukraine. These gender discrepancies raise complex questions related to cultural context, public policy and the content of health education programmes.

The HBSC study is not the ideal means of providing a complete picture of age at initiation of sexual activity because even the oldest participants are only in their sixteenth year of life, when the majority of young people have not yet started to be sexually active. Nevertheless, the pop-

ulation identified as sexually active in the study consists largely of early initiators who by definition are seen to be at higher risk of unplanned, unprotected intercourse and other risk behaviours associated with impulsiveness. On the other hand, with some noteworthy exceptions, a high percentage of these early initiators in many countries and regions reports using condoms. This suggests that young people not only have received the various messages on safe sex but also seem largely to have accepted and acted on them.

Further analyses of contraceptive methods are planned to gain understanding of the differences in specific contraceptive practices across HBSC countries and regions and to develop an efficient, age-group measure of these practices. Further analysis will also be conducted to explore the differences in risk and protective factors connected with sexual behaviour among individuals and across countries.

## References

1. Currie C et al., eds. Young People's Health in Context. Health Behaviour in School-aged Children: international report from the 2001/2002 survey. Copenhagen, WHO Regional Office for Europe, 2004 (Health Policy for Children and Adolescents, No. 4).
2. Raphael D. Determinants of health of North-American adolescents: evolving definitions, recent findings, and proposed research agendas. *Journal of Adolescent Health*, 1996, 19:6–16.
3. Kolbe LJ, Kann L, Collins JL. Overview of the Youth Risk Behavior Surveillance System. *Public Health Reports*, 1993, 108(Supplement 1):2–10.
4. Brener N et al. Reliability of the Youth Risk Behavior Survey questionnaire. *American Journal of Epidemiology*, 1995, 141(6):575–580.
5. Brener N, Kann L et al. Reliability of the 1999 Youth Risk Behavior Survey questionnaire. *Journal of Adolescent Health*, 2002, 31:336–342.
6. Orr DP, Fortenberry JD, Blythe M. Validity of self-reported sexual behaviors in adolescent women using biomarker outcomes. *Sexually Transmitted Diseases*, 1997, 24:261–266.
7. Flanigan, BJ, Hitch MA. Alcohol use, sexual intercourse and contraception: an exploratory study. *Journal of Alcohol and Drug Education*, 1986, 31(3):6–40.
8. Robertson JA, Plant MA. Alcohol, sex and risks of HIV infection. *Drug and Alcohol Dependence*, 1988, 22(1):75–78.
9. Traeen B, Lundin Kvaalem I. Sex under the influence of alcohol among Norwegian adolescents. *Addiction*, 1996, 9(7):995–1006.
10. Morris L, Warren CW, Aral SO. Measuring adolescent sexual behaviors and related health outcomes. *Public Health Reports*, 1993, 108(Suppl. 1):31–36.

*The full report and further information about HBSC is available at [www.hbsc.org](http://www.hbsc.org).*

### James Ross

[james.g.ross@orcmacro.com]:  
Vice President,  
Macro International Inc.,  
Maryland, USA

### Emmanuelle Godeau

Service médical du Rectorat,  
Association pour le développement d'HBSC and Inserm U558,  
Toulouse, France

### Sonia Dias

Faculdade de Motricidade Humana,  
Universidade Tecnica de Lisboa

# YOUTH-FRIENDLY HEALTH SERVICES: WHY DO YOUNG PEOPLE NEED SPECIAL SERVICES?

*Elina Juntunen*

In most of the world, the majority of young people become sexually active during their adolescence. In the past, unmarried young women and men were systematically excluded from family planning and sexual and reproductive health (SRH) services, and this is still a reality for many young people in various countries.



However, it has now been realized that young people – whether they are married or unmarried – need these services just as much as older, married couples. With 1.2 billion adolescents and half of the world's population under the age of 25, more young people than ever need reproductive health care and prevention services.

The necessity to invest in young people's SRH services is not only demonstrated by the alarming increase in sexually transmitted infections (STIs) among young people and the HIV/AIDS pandemic – young women representing the fastest-growing group, infected and affected by HIV/AIDS – but also by the huge unmet need of young people's possibilities for family planning and the subsequent number of unwanted pregnancies and unsafe abortions.

Given that young people tend not to (ie do not always have access to) use the existing SRH services, other alternative approaches must be implemented. The non-use of existing services is due to the fact that young people face many barriers to use sexual and reproductive health services, for example laws and policies may restrict young people's access to affordable services and correct information, or they may feel embarrassed at being seen at clinics or, simply, they do not have information that such services exist. Sometimes, the negative attitudes of the service providers limit young people's access to SRH services.

Gold standard of youth-friendly services Youth-friendly services are needed in order to provide young people with sexual and reproductive health care. The key elements in youth-friendly services are the principles of privacy, confidentiality and respect for young people, accessibility, gender-friendliness, specially trained service providers and the involvement of young people in the planning and implementation as well as evaluation of youth-friendly services and programmes. Young people can best help to determine the characteristics that best relate to their needs.

According to UNFPA youth-friendly health services should ensure that there is adequate time for client-provider interaction, peer counsellors are available, facilities have convenient hours and location, there is no overcrowding and not too long waiting times. In addition, drop-in clients are welcome or appointments are arranged quickly, and a wide range of services and necessary referrals are available as well as educational material and group discussions.

Youth-friendly sexual and reproductive health services should ensure that accurate information and counselling, when necessary, are given to young people. Sexuality education should be given to children before sexual initiation. Some adults believe –mistakenly – that sexuality education leads to earlier sexual activity and promiscuity. This is not the case.

It delays sexual activity and increases safer sexual practices, contributing to better well-being of youth and their empowerment and self-determination. Information should be disseminated in and out of school surroundings. Also, reproductive health commodities should be easily available for young people.

## Legislation alone is not enough

Special training to service providers is highly important as many young people face the restrictive attitudes of staff when seeking access to SRH services. In Portugal, for example, the legislation acknowledges youth's right to SRH information and services but the reality is often different: depending on the clinic or pharmacy, young people can be sent away when seeking help, e.g. trying to obtain emergency contraception..

In Finland, there is a legislation that safeguards the rights of young people to have access to health services and, contrary to Portugal, it is also implemented. The negative attitudes of health care personnel towards youth are very rare and issues dealing with sexuality can be discussed. Finland has low rates of HIV/AIDS, unwanted pregnancies and STIs among young people, though the incidence of Chlamydia is currently increasing. Maybe, the youth-friendliness of the services could be emphasised even more.





This past May, YouAct, a European Youth Network on sexual and reproductive rights, was officially launched in Lisbon, Portugal. Thirty-seven young people from 20 European countries gathered to participate in a youth conference organized by YouAct to celebrate its launch.



### An endless road or just a long way to go?

At the International Conference on Population and Development in 1994, it was promised that young people's SRH needs must be addressed and met: young people have the right to SRH information, education and services. The goal of universal access to family planning, including young people, was set at that time. The road that was paved – ten years ago – is a solid foundation, but there is a long way to go and true actions are needed. The goal can be reached, but it is largely dependent on the priorities of the governments.

In conclusion, I am urging governments to take the responsibility for the promises made; not only words, but deeds are needed, which means more funding for sexual and reproductive health programmes that especially target adolescents' needs. It is true that the resources are often scarce when it comes to health care and sexual and reproductive health services. However, the investments give generous returns as the rates of STIs and HIV/AIDS decline, as well as the number of unwanted pregnancies and unsafe abortions. Young people's access to sexual and reproductive health services and especially youth-friendly services, including information and counselling, is an imperative. The health and well-being of this generation will have a vast impact on the future.

### What you as a young person can do

Some things we, young people, can do are:

- make a resolution of the importance of youth-friendly health services and send it to the decision-makers of your community/country;
- work together with your local NGOs to address the issue;
- write in newspapers and magazines;
- work/advocate together with other young people, together we are more powerful.

The youth conference addressed sexual and reproductive health and rights issues in the European Region as well as in different countries. Participants followed workshops on youth participation and international agreements (e.g. the International Conference on Population and Development and its relationship with the Millennium Development Goals) and learned about opposition in the field. There were speakers from the Portuguese Youth Institute, the Portuguese Institute against Aids, the Portuguese Family Planning Association (APF) and Marie Stopes International (MSI).

One of the relevant outcomes included access to sex education, and the need to include sex education in school curricula. A human rights based approach was proposed as a necessary guideline within sex education. On top of working on youth issues, the participants expressed them-

selves creatively in a graffiti-painting activity.

The next step is that young people can now become members of YouAct. In order to become a member they can contact the secretariat for more information and an application form. A first general meeting will soon be organized where taskforces will be formed and the final steering committee will be elected.

### For more information

Anneke Wensing  
Youth Co-ordinator CHOICE  
c/o WPF Amperestraat 10  
1221 GJ Hilversum  
The Netherlands  
Tel: (+31) 35 6422304

### Elina Juntunen

[Elina.juntunen@vaestoliitto.fi]  
YouAct, the European Youth  
Network on Sexual and  
Reproductive Rights

# THE NEED FOR YOUTH FRIENDLY HEALTH SERVICES IN SOUTH-EAST EUROPE

Jeffrey V. Lazarus



The United Nations Inter-Agency Group (IAG) on Young People's Health, Development and Protection sub-group on Youth Friendly Services (YFS) held a consultation, in Bulgaria, in September 2003. It was designed as a forum to share experiences of implementing YFS in south-east Europe and examples of good practices from other countries. In addition, the consultation included presentations to stimulate discussion on elements of YFS with specific reference to the health sector.

The main objectives of the Sofia meeting were to examine the concept of youth friendly services (YFS) and apply the criteria of YFS to existing service provision, with a special focus on quality norms and standards in YFS provision, scaling up good practice and identifying indicators to measure accessibility, acceptability, appropriateness, affordability, coordination between agencies and youth participation. Youth friendly services are those which are based on the needs and rights of children and young people, and the responsibilities of duty bearers to promote young people's health and development and provide quality services.

Participants included teams of senior decision-makers, YFS programme managers, non-governmental organizations and young people from Albania, Bosnia & Herzegovina, Bulgaria, the former Yugoslav Republic of Macedonia, the Republic of Moldova, Romania, Serbia and Montenegro, and the United Nations Administered Province of Kosovo. In addition, resource people from Estonia and Lithuania and members of the IAG

(UNFPA, UNICEF and WHO at the country and regional levels) attended, as well as representatives of the German Agency for Technical Cooperation and the World Bank.

The problems experienced by young people during the transition process in south-east Europe were identified as increasing use of drugs, often through injecting them, and other forms of substance abuse (especially alcohol and tobacco), and rapidly increasing rates of stress and mental ill health linked – in some countries – to alarming increase in suicide rates amongst young men. An increasing number of young people are now homeless and on the street.

Participation by young people in civic and political life is low. In addition, reproductive health indicators show that the prevalence of contraceptive use is low, abortion rates are high, maternal and infant mortality rates are rising, and the incidence of sexually transmitted infections shows an upward trend.

HIV/AIDS is spreading faster in parts of the European Region than in anywhere else in the world, and young people are at the centre of the epidemic. In some countries, up to 80% of infections are occurring among young people. While the majority of infections are attributed to injecting drug use, heterosexual intercourse has also become a prominent mode of transmission of HIV.

A key element of YFS is the full participation of young people in the design, implementation and monitoring of these services. The IAG has developed a regional framework for YFS with three components: advocacy; integration into local government and health care reform

including capacity building of service providers; and quality of care: norms, standards and indicators for YFS. As a precursor to the meeting, mapping was undertaken in each of the countries/entities represented on the status of existing services that young people can use. The areas where much more work needs to be done are in developing local and national intersectoral coordination structures and norms and standards for YFS, training service providers in youth friendly approaches, and ensuring sustainability of YFS and participation of young people in service delivery.

At the meeting, it was agreed that YFS should be promoted by governmental structures in collaboration with young people, media, civil society and international institutions, that YFS should be integrated into government services using existing resources, and that there was an urgent need to go to scale with YFS, building on existing good practice.

A CD-ROM with the background papers and all of the presentations is available upon request from Mr David Rivett [dri@euro.who.int], technical adviser, Health Promotion and Research, the WHO Regional Office for Europe.

Jeffrey V. Lazarus  
[jla@euro.who.int]

Rapporteur, Inter-country consultation on youth friendly services in south-east Europe, held by the United Nations Inter-Agency Group on Young People's Health, Development and Protection in Europe and central Asia, Sub-group on Youth Friendly Services

# CAIRO AND BEYOND: REPRODUCTIVE RIGHTS AND CULTURE

7-9 March 2004, Amsterdam, Conference Report

Evert Ketting

The Cairo and beyond conference, held on International Women's Day, was an initiative of the Dutch Minister of Development Cooperation, Mrs Agnes van Ardenne, and the Executive Director of UNFPA, Mrs Thoraya Obaid. The conference was the first substantive activity in the field of reproductive rights and culture. As such, it was primarily exploratory in nature.

## Background

The Programme of Action of the International Conference on Population and Development (ICPD), held in Cairo in 1994, is increasingly being attacked by conservative institutions and governments. Since George Bush came to power, the US administration has taken the lead in this anti-Cairo "War on Women", often in collaboration with influential religious leaders and representatives of conservative governments. Those working on the implementation of the Cairo agenda are increasingly frustrated by the pressing need to spend most of their time and energy on protecting this agenda at the expense of implementing it. Until now attempts to break the consensus have not really been successful, but they did result in a decision not to have a full "Cairo+10" international conference.

Those promoting "Cairo" feel defensive, and tend to perceive traditional, particularly religious, institutions and their representatives as their adversaries; these are the "obstacles" that prevent implementation of the agenda, and that have to be removed. Tradition, religion or more generally "culture" is thus predominantly perceived as the enemy of internationally recognized sexual and reproductive rights, and at best the relationship between these rights and "culture" is a taboo subject. Nevertheless, the interrelationships between reproductive rights and culture should be taken more serious, and it is useful to explore where and to what extent culture can be a facilitating factor in granting people their sexual and reproductive rights. As Mrs Van Ardenne stated in her welcome address: "We do not often use the possibilities of culture; we only see it as an obstacle". Turning these cultural obstacles into potential opportunities for the promotion of reproductive rights was the theme of the conference. Mrs Obaid added to this that what we really need is a non-dogmatic attitude. But Fred Sai, who had been the chairman of ICPD ten years earlier, also warned that we often abuse "culture" to justify social inequality.

Officially, the conference objective was "to formulate recommendations and give practical examples of ways in which people and societies can positively use their culture for the implementation of the ICPD Programme of Action".

## An unorthodox conference

About 90 scientists, women's health activists, politicians and other specialists from all parts of the world were invited to this conference. Among them were seven ministers or ex-ministers and eleven ambassadors. The conference started with a conference dinner prepared by ... the conference participants themselves, for whom this was a big surprise. But cutting onions, stirring sauces and peeling eggs together, while having informal talks in four or five groups in different kitchens, all dressed in the same "www.reproductiverightsandculture.org" aprons, worked very well as an icebreaker.

Also, in other respects the conference had an unorthodox character. Readymade resolutions were not prepared beforehand; instead participants were invited to share their own ideas and experiences on the issue of reproductive rights and culture, which resulted in very lively discussions. The informal character of the meeting was strengthened as participants had been invited to bring some typical cultural symbols from their own countries. These objects were hung on the branches of an artificial tree, and participants were invited to guess where a particular object came from and what its cultural meaning would be.

At the end of the conference there was a similar and very interesting conversation with five (former) female ministers, from Afghanistan, China, Estonia, Senegal and Yemen. In spite of strong differences between them, they agreed that men have to be educated to respect women's (reproductive) rights. They also expressed their concerns on the diminishing international commitment to implementing the Cairo Agenda.

## Three sub-themes

The participants worked for most of the time in three groups, with each group subsequently discussing three central issues:

- constructing identities: addressing adolescent's rights and sexual and reproductive health needs;
- understanding the multiple dimensions of religion in promotion and protection of reproductive and sexual health and rights;
- bridging synergies between and



among institutions and social actors. One remarkable figure was Canon Gideon Byamugisha, from Uganda, “the first practicing HIV positive priest in Africa”, as his CV put it. He was the living example of a church representative who is devoting his life to the fight against AIDS. He had publicly declared his HIV status as early as 1992. Being a real performer, he gave the discussants his own interpretation of the A, B, C, rule (abstinence, be faithful, condom use) in AIDS prevention: “if you are unable to do A, B, or C, then do ‘D’: Die.”

But there were also many critical remarks. A representative from Argentina warned that it sounds very positive and encouraging to start dialogues with the opposition, but how to do this, if you are being threatened by these fundamentalists. And a representative from The Netherlands felt that the discussion here was just among “believers” (in the Cairo Agenda); the opponents were not present.

The issue of adolescent sexual and reproductive rights turned out to be the most controversial one. There was some form of consensus on their rights, but clear disagreement on adolescent sexual and reproductive behaviour. In fact, the discussion at this point hardly focussed on rights versus culture, but much more on youth involvement and effective ways

of working with youth. It became (again) clear that there is a wide gap between the European philosophy and approach of accepting that young people at some stage in their development are sexually active, and the reality in most of the rest

*“Sexuality is the only field where it is said that if people have the knowledge they are going to do the wrong thing”*

Fred Sai

of the world, where sexual activity before marriage is unacceptable.

#### Conference results

The price paid for the explorative and open-ended character of the conference was that there were few concrete and tangible results. The participants were encouraged to further explore possibilities to work alongside instead of against culture, but it was far too early to come up with a concrete plan of action.

Under the title “A Turning Point”, ten conclusions were presented and are available on the conference website ([www.reproductiverightsandculture.org](http://www.reproductiverightsandculture.org)).

Conclusion number nine announced that this website, supported by the Netherlands government, will be maintained as a virtual network and a forum for the exchange of best practices and views. But only three of the other conclusions were clearly on the issue of reproductive rights and culture, while the remainder primarily stressed the need for continued commitment to the implementation of the ICPD Programme of Action.

In her closing speech, Mrs Van Ardenne asked for another donor government to organize a follow-up conference next year on the same issue. She herself will organize another follow-up in the form of a conference on 8 March 2005, focusing on the meeting of generations, in which youth will be fully involved.

Cairo and Beyond [www.reproductiverightsandculture.org/](http://www.reproductiverightsandculture.org/)



Evert Ketting

[e.ketting@tip.nl]

Chairman, working group on sexual and reproductive health, Share-net, the Netherlands



# CONFRONTING HIV/AIDS: HOW NGOS CAN ACHIEVE GREATER YOUTH INVOLVEMENT

- A catalogue of ideas

Lise Rosendal Østergaard, Bjarne B. Christensen and Jeffrey Victor Lazarus

**Young people under 25 must be a priority in the prevention of HIV/AIDS as, globally, they continue to make up a considerable proportion of those newly infected each year.**



They are crucial partners in the fight against the pandemic and inasmuch as HIV is primarily sexually transmitted, their sexual and reproductive health needs must be adequately addressed.

In recognition of this, the Danish Family Planning Association (Foreningen Sex & Samfund) has prepared a catalogue of ideas on how non-governmental organizations (NGOs) can achieve greater youth involvement in the fight against HIV/AIDS in low-income countries. The aim is to stimulate discussion and to foster new thoughts on how to address existing barriers to involving young people in HIV/AIDS prevention projects.

The catalogue specifically addresses the NGO level, but it is also relevant for policy-makers, advocates, youth activists and for those interested in knowing more about the conceptual background for youth participation as well as ways to check the youth friendliness of the institutional culture in any organization. It is based on the assumption that young people might not necessarily benefit from an up-scaling in HIV/AIDS services because they do not regularly use health care facilities or because they experience certain barriers to access. Even when youth friendly health care services are available, stigma, discrimination or gender-based

stereotypes might discourage their use.

The catalogue provides specific examples from young people themselves involved in NGO HIV/AIDS prevention activities from such different countries as Armenia, Denmark, Mexico, the Philippines and Uganda. The point of departure is based on the following learning points:

- HIV/AIDS education needs to emphasize risk factors for HIV infection since a great majority of sexually active young people underestimate their own possible exposure to the virus;
- special strategies are needed for providing information to adolescents and young women because they are often disadvantaged in terms of formal education and exposure to other kinds of HIV prevention messages; and
- prevention messages need to be specifically tailored to either married or single young women.

## Barriers to youth participation

Based on input from an international group of young people and adults that were gathered at the International Mahler Forum, held in Copenhagen, Denmark, in August 2001, the most important barriers to youth participation are discussed. Suggestions are provided on how these barriers and conflicts can be addressed. We argue that progress towards the meaningful participation of young people requires a change in the concept, language and practice of the "business culture" of an institution.

In the eyes of young people these include among others poor communication skills among service providers and school teachers. As a Finnish participant noted: "Talking about young people's sexuality is very often automatically associated with irresponsible and experimental "running around". How can we, the adults, understand young people's sexuality in a broader sense, one that also includes feelings and love?". Young people also referred to gender stereotypes as an underlying cause of young women's exposure to HIV/AIDS. A 23-year-old female peer educator from Uganda explains how she has managed to build up life skills that allow her to regain control over her life through education, supportive parents and a volunteer job: "I

have also decided that I will have only one sexual partner ... I keep off drugs and avoid being in compromising situations like getting drunk in nightclubs. I have resisted gifts or money from men as there is always a price to pay and it's usually in kind".

## Ideas to involve young people in the project cycle

The intention of the catalogue is to promote ideas that ensure that as many youth and adolescents as possible – in accordance with their wishes, resources and time – participate in a meaningful way at all stages of a given project.

Young people are often only involved at the final stages of a project cycle, when their voices have little or no impact. NGOs must remember that young people are stakeholders that hold an influence on projects affecting them. Specific guidelines as well as a so-called 'ladder of participation' to measure youth involvement in a given programme are described in the catalogue. We argue for a shift from involving young people at select steps of the project cycle, typically implementation, to systematic and coherent involvement from idea development to preparation, implementation, monitoring and evaluation, in addition to advocacy.

The Catalogue of Ideas has been published with technical and financial support from AIDSNET, the Danish NGO Network on AIDS and Development, and was launched at the International AIDS Conference in Bangkok, in July 2004. It is available free of charge (except for postage and packaging costs) from the Danish Family Planning Association [info@sexogsamfund.dk].

**Lise Rosendal Østergaard**  
[lro@aidonet.dk]

Co-ordinator, AIDSNET, the Danish NGO Network on AIDS and Development

**Bjarne B. Christensen**  
Executive Director, the Danish Family Planning Association

**Jeffrey Victor Lazarus**  
Board member of the Danish Family Planning Association

## The Young Person's Guide to the UN Convention on the Rights of a Child and Sexual and Reproductive health

This guide makes the links between the rights, as laid out in the Convention, and sexual and reproductive rights – traditionally one of the most controversial areas in United Nations discussions. The United Nations Convention on the Rights of the Child is the most powerful legal instrument available to all children for the protection and enforcement of their human rights. It has been ratified by every country in the world, with the exception of the USA and Somalia. By ratifying this instrument, national governments have committed themselves to protecting and ensuring children's rights and they have agreed to hold themselves accountable for this commitment before the international community. Despite this, there has been little progress in the protection and promotion of adolescent sexual and reproductive health. Written for young people, in a clear, youth-friendly language, the guide aims to highlight specific links between this legally binding international instrument and sexual and reproductive health.

Available at  
[www.ippf.org/youth/young\\_person.htm](http://www.ippf.org/youth/young_person.htm)

## Good Lovers: A multi-dimensional concept for sexuality education

The concept of “good lovers” has been developed to meet the needs of young people and children, on the one hand, and the questions of sexuality educators (e.g. parents, teachers, health professionals) on the other.

The three main objectives in becoming a good lover are:

- sexual development: children and young people deserve age appropriate information, help and experience in the field of intimate relationships, sexuality, gender identity and sexual orientation;
- sexual morality: values and norms are to be discussed and learned;
- Prevention of risky behaviour, sexual abuse, unwanted pregnancy and HIV or other sexually transmitted infections.

The concept is published as a text for professionals (English version available), and materials for teachers and young people have been developed and evaluated. And for those near or in Belgium, the interactive exhibition “Carrousel Good Lovers” ([www.goedeminnaars.be](http://www.goedeminnaars.be)) can be visited by schools and parents in a school museum (Wereld van Kina).

Free copies can be ordered at [www.sensoa.be](http://www.sensoa.be)



## UNFPA Global Population Policy Update

This newsletter is issued by the United Nations Population Fund (UNFPA) in its capacity as secretariat for the biannual International Parliamentarians' Conference on the Implementation of the ICPD Programme of Action (the first conference was held in November 2002, in Ottawa, Canada). These dispatches are intended to highlight important developments taking place around the world so that parliamentarians can be kept informed of and learn from the successes, setbacks and challenges encountered by their fellow parliamentarians in other countries and regions in their efforts to promote the implementation of the Programme of Action of the International Conference on Population and Development (September 1994, Cairo, Egypt). It should be noted that UNFPA does not necessarily endorse all of the policies described in this newsletter.

Please contact Ragaa Said [[said@unfpa.org](mailto:said@unfpa.org)] to join the mailing list.

## Dance4Life

Dance4Life is the first bi-annual, international project organized by young people to fight and prevent HIV and AIDS. On the Saturday preceding World Aids Day 2004 - Saturday 27 November 2004 - a spectacular, cultural, five hour multimedia event will be organized in different parts of the world. Famous DJs, VJs, dancers, bands and special acts from Africa and Europe will draw attention to the devastating magnitude of the “silent disaster”: HIV and AIDS.

More than 80 000 young people will dance simultaneously in South Africa, France the Netherlands and quite possibly the Russian Federation too. No country in the world is showing such a dramatic increase as Russia. And here, too, young people suffer the most. More information about these organizations and the projects that they will realize through Dance4Life can be found on [www.dance4life.com](http://www.dance4life.com)



## United Nations issues World Population Policies 2003

New York, 24 March (Department of Economic and Social Affairs) – The Population Division has issued World Population Policies 2003, which contains the most comprehensive and up-to-date information available on the population policy situation for all 194 Member and non-Member States of the United Nations.

This publication provides an overview of population policies for every country as of 2003, and at mid-decade for the 1970s, 1980s and 1990s – that is, at the time of the United Nations international population conferences at Bucharest, Mexico City and Cairo.

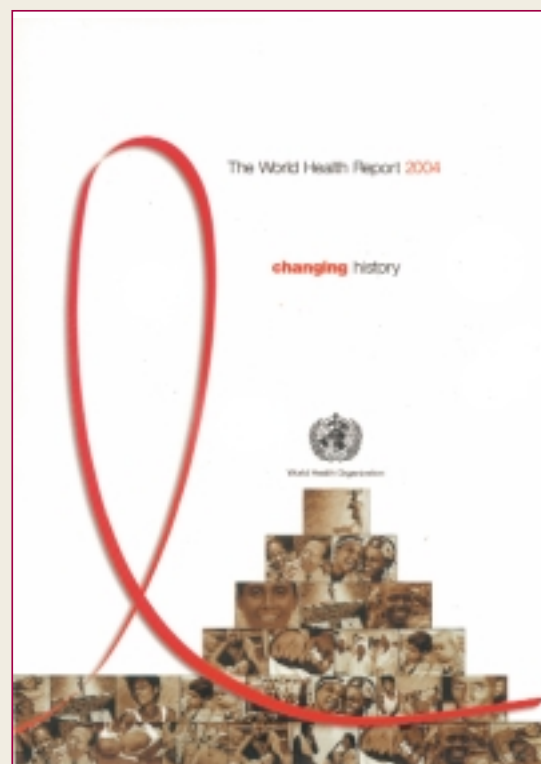
The study includes information on national population policies in relation to population growth, population age structure, fertility, mortality, spatial distribution and international migration. In order to provide the proper background, key demographic indicators are also presented for each country.

High mortality is the most significant population concern for developing countries. Over 80 per cent of developing countries list infant and child mortality, maternal mortality and HIV/AIDS as the most pressing population and development issues. The most significant demographic concern of the developed countries relates to low fertility and its consequences, including population ageing and the shrinking of the working-age population.

This issue of World Population Policies 2003 is being released during the tenth anniversary celebration of the adoption of the Programme of Action of the International Conference on Population and Development. This compendium and analysis of national population policies contributes to the deliberations of the thirty-seventh session of the Commission on Population and Development, which is reviewing and appraising the progress made in achieving the goals and objectives of the Programme of Action. The Programme of Action recommended that actions should be taken to "measure, assess, monitor and evaluate progress towards meeting the goals of the present Programme of Action". To that end, this study addresses governments' views and policies across many of the critical areas covered in the Programme.

For additional information, please contact the office of Joseph Chamie, Director, Population Division, Department of Economic and Social Affairs, United Nations, New York, N.Y. 10017, USA; tel.: (+1) 212 963-3921 or fax: (+1) 212 963-2147; [www.unpopulation.org](http://www.unpopulation.org).

**World Population Policies 2003 (Sales No. E.04.XIII.3, ISBN 92-1-151393-6) is available for US\$ 55.00 from United Nations Publications, Two UN Plaza, Room DC2-853, Dept. PRES, New York, NY 10017 USA; tel. (+1) 800-253-9646 or (+1) 212-963-8302, fax: (+1) 212-963-3489, E-mail: [publications@un.org](mailto:publications@un.org); or Section des Ventes et Commercialisation, Bureau E-4, CH-1211, Geneva 10, Switzerland, tel.: (+41) 22-917-2614, fax: (+41) 22-917-0027, E-mail: [unpubli@unog.ch](mailto:unpubli@unog.ch); [www.un.org/publications](http://www.un.org/publications).**



## Europe sees the fastest increase in HIV/AIDS

WHO Warns More Resources Must Be Mobilised to Treat HIV Epidemic

"Changing History", a report published by the World Health Organization (WHO), indicates that HIV/AIDS is spreading through Europe faster than anywhere else in the world. Around 2.5 million people on the continent are HIV positive or have AIDS.

HIV/AIDS is travelling fastest through eastern Europe: 370,000 new cases were identified in 2003, in 1995 there were only 27,000 cases. Countries with the fastest growing epidemics include the Ukraine, Russia and Estonia. The increase has been attributed to increased levels of drug use and sharing needles, and to a lesser extent unsafe sex.

The report, launched on the eve of the annual World Health Assembly in Geneva, in May, also focuses on the amount of resources required to stave off the HIV epidemic. The report says a "major transfer of resources" from the rich world to the poor world is needed to quell the epidemic.

It also highlights the plight of several poorer European nations. The poorer countries are rarely eligible for the reduced drug prices, yet one in five countries in the region has a gross national product of less than US \$1 000 per head. In 22 countries about 100 000 people need treatment but only 6 500 are receiving it.

## *Entre Nous*

*The European Magazine  
for Sexual and Reproductive Health*

WHO Regional Office for Europe  
Reproductive Health and Research Programme

Scherfigsvej 8

DK-2100 Copenhagen Ø

Denmark

Tel: (+45) 3917 1341 or 1451

Fax: (+45) 3917 1850

[[entrenous@who.dk](mailto:entrenous@who.dk)]

[www.euro.who.int/entrenous](http://www.euro.who.int/entrenous)



# Entre Nous