

# Adolescent Friendly Health Services



An Agenda for Change



World Health Organization

*Adolescent Friendly Health Services —  
An Agenda for Change*

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# Adolescent Friendly Health Services



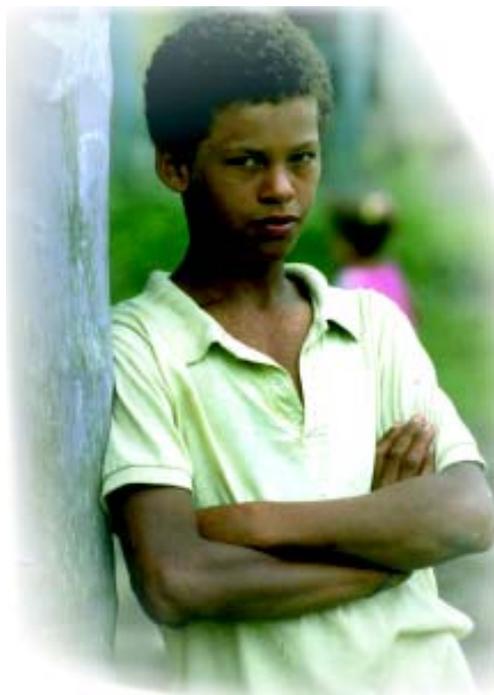
An Agenda for Change



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# *An agenda for change*



**A**dolescents complete their physical, emotional and psychological journey to adulthood in a changing world that contains both opportunities and dangers.

Most adolescents are full of optimism and represent a positive force in society, an asset now and for the future as they grow and develop into adults. When supported, they can be resilient in absorbing setbacks and overcoming problems.

However, adolescents are exposed to risks and pressures on a scale that their parents did not face. Globalisation has accelerated change while the structures that protected previous generations of young people are being eroded. Adolescents receive contradictory messages on how to address the daily choices which have lifelong consequences for healthy development. Millions are denied the essential support they need to become knowledgeable, confident and skilled adults. They miss out on schooling for economic reasons or because their communities are displaced or disrupted by war or conflict.

And, while most young people have loving families who protect and care for them, many grow up with no adults committed to their welfare or where the ability of caring adults to support them has been damaged.

Adolescents are at risk of early and unwanted pregnancy, of sexually transmitted infections (STIs) including HIV and AIDS, and vulnerable to the dangers of tobacco use, alcohol and other drugs. Many are exposed to violence and fear on a daily basis. Some of the pressures adolescents are under, or the choices they make, can change the course of their young lives, or even end them. These outcomes represent personal tragedies for young people and their families. They are also unacceptable losses that put the health and prosperity of society at risk.

Addressing the needs of adolescents is a challenge that goes well beyond the role of health services alone. The legal framework, social policy, the safety of communities and opportunities for education and recreation are just some of the factors of civil society that are key to adolescent development.

However, within an integrated approach, health services can play an important role in helping adolescents to stay healthy and to complete their journey to adulthood; supporting young people who are looking for a route to good health, treating those who are ill, injured or troubled and reaching out to those who are at risk.



*Adolescence — for some a time of play, for some a time of work, for most a period of optimism, but for some a time of dashed hopes.*

*Photo: WHO*

Effective health services reach adolescents who are growing up in difficult circumstances as well as those who are well protected by their communities. Health services need to link with the other key services for adolescents, so that they become part of a supportive structure that protects young people against dangers, and helps them to build knowledge, skills and confidence.

This is far from being the case in many countries. Health services often regard adolescents as a healthy group who do not need priority action, and so provide a minimum subset of adult or paediatric services with no adjustments for their special needs.

There is evidence that many young people regard such health services as irrelevant to their needs and distrust them. They avoid such services altogether, or seek help from them only when they are desperate.

This document explains why it is important that service providers address the problems of adolescents to make health services relevant and attractive. It shows how some professionals are breaking down barriers between health services and young people to enlist adolescents as champions of their own health.

### Summary

- **Adolescents represent a positive force in society, now and for the future.**
- **They face dangers more complex than previous generations faced, and often with less support.**
- **The development needs of adolescents are a matter for the whole of civil society.**
- **Health services play a specific role in preventing health problems and responding to them.**
- **Many changes are needed in order for health services to become adolescent friendly.**

‘Adolescent friendly’ health services meet the needs of young people in this age range sensitively and effectively and are inclusive of all adolescents. Such services deliver on the rights of young people and represent an efficient use of precious health resources. Their characteristics are further spelled out in this document. ■

# Who are adolescents?



**T**he World Health Organization defines adolescents as young people aged 10-19 years. There are about 1.2 billion adolescents, a fifth of the world's population, and their numbers are increasing. Four out of five live in developing countries.

Adolescence is a journey from the world of the child to the world of the adult. It is a time of physical and emotional change as the body matures and the mind becomes more questioning and independent.

The second decade of life is a period of personal development almost as rapid as the first. Ten-year-olds are still children, although many are already exposed to challenges from the adult world. By the age of 20, young people are contributing members of society, acquiring rights at a variety of ages to marry, vote, drive, have sex, fight for their country — or to go to prison.

Adolescents are no longer children, but not yet adults, and this period of change is full of paradox. Adolescents can seem old beyond their years, but need adult support. They can put themselves at risk without thinking through the

consequences; display optimism and curiosity, quickly followed by dismay and depression. Biologically, they can become mothers and fathers, without being ready for the responsibility. They feel a growing sense of independence, but depend on adults for their material needs. And as they change, so their needs change with them.

- Early adolescence (10-13) is characterised by a spurt of growth, and the beginnings of sexual maturation. Young people start to think abstractly.
- In mid-adolescence (14-15) the main physical changes are completed, while the individual develops a stronger sense of identity, and relates more strongly to his or her peer group, although families usually remain important. Thinking becomes more reflective.
- In later adolescence (16-19) the body fills out and takes its adult form, while the individual now has a distinct identity and more settled ideas and opinions.

These changes take place at a different rate for each individual and can be a period of anxiety as well as pride. Part of the challenge for health



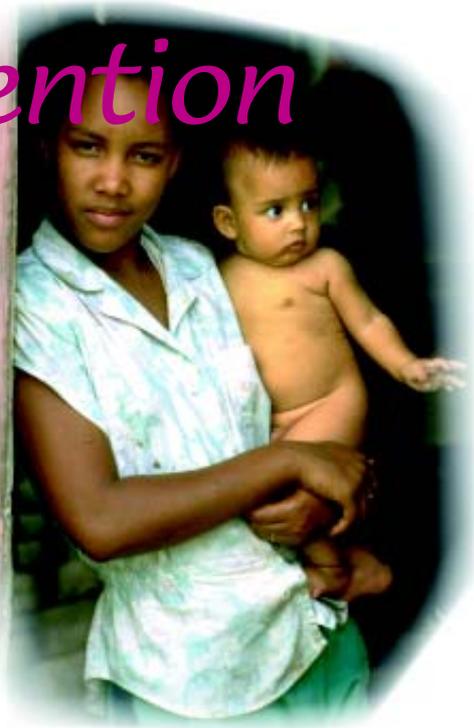
services is to recognise that adolescents have a range of needs based on individual circumstances. Those who are especially vulnerable and hard to reach, include young people who:

- are denied the opportunity to complete their education;
- have no stable homes or support, living rough in towns and cities, exposed to risks of mal-nutrition, abuse, violence and disease;
- are vulnerable to sexual abuse or violence, or are sexually exploited by people who are older and more powerful;
- work long hours for little pay, exposed to hazardous work processes;
- live in war zones where society has been shattered by conflict, and where some become involved in violence while still children;
- are displaced into camps where traditional values and community structures are impossible to maintain;
- live as young wives in families who oppress and abuse them;

### Summary

- **About one fifth of the world's population are adolescents, aged 10-19 years.**
  - **The majority of adolescents live in developing countries.**
  - **Adolescents are no longer children but not yet adults.**
  - **Adolescents have different needs according to their stage of development and their personal circumstances.**
  - **Some adolescents are especially vulnerable or hard to reach, and are in extra need of support.**
- live as ethnic minorities in a land where they and their parents are rejected by mainstream culture;
  - are among the 1 in 10 young people affected by a disability, and denied the same opportunities for development as their peers.

# Why pay attention to the health of adolescents?



**A**dolescents are generally believed to be healthy because death rates for this age group are lower than for children or for elderly people. However, death rates are an extreme measure of health status and tell only part of the story. There are many interrelated reasons why we need to pay attention to the health of adolescents: for this age group, for later life and for the next generation.

- **To reduce death and disease in adolescents now**

An estimated 1.7 million young people aged from 10 to 19 die each year — mainly from accidents, violence, pregnancy related problems or illnesses that are either preventable or treatable. Many more develop chronic illness that damage their chances of personal fulfilment.

- **To reduce the burden of disease in later life**

Malnutrition in childhood and in adolescence can cause lifelong health problems, while failure to care for the health needs of young pregnant women can damage their own health and that of their babies.

This is the age when sexual habits and decisions about risk and protection are formed. Some of the highest infection rates

for sexually transmitted infections are in adolescents. The HIV/AIDS pandemic alone is sufficient reason to look anew at how health services address the needs of adolescents.

Many diseases of late middle age, such as lung cancer, bronchitis and heart disease, are strongly associated with a smoking habit that begins in adolescence.

- **To invest in health — today and tomorrow**  
Healthy and unhealthy practices adopted today may last a lifetime. Today's adolescents are tomorrow's parents, teachers and community leaders. What they learn they will teach to their own children. Adolescence is a period of curiosity, when young people are receptive to information about themselves and their bodies, and when they begin to take an active part in decision making.

- **To deliver on human rights**

The Convention on the Rights of the Child (CRC) says that young people have a right to life, development, and (Article 24) “the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health”. The CRC gives young people the right to preventive health

care, and calls for specific protection for those in exceptionally difficult conditions or living with disabilities. Under the CRC, Governments not only have a duty to ensure services for good health care, but also have a duty to ensure that young people can express themselves and that their views are given weight according to their age and maturity.

- **To protect human capital**

In some societies two out of three adolescents are involved in productive work, while many young women below the age of 20 are already mothers. If they are no longer able to fulfil these roles because of injury, illness or psychological damage, the cost is primarily a human one, but there is also a cost to society.

### Summary

**We need to pay attention to the health needs of adolescents to:**

- **reduce death and disease, now and during their future lives.**
- **deliver on the rights of adolescents to health care, especially reproductive health care;**
- **ensure that this generation of adolescents will, in turn, safeguard the health of their own children.**

Economic development, as well as personal fulfilment, is strongly related to the health and education levels of the population. ■

### Sexual and reproductive health care is a human right

Access to sexual and reproductive health services is a human right, based on the equality of women and men. The Convention on the Elimination of All Forms of Discrimination against Women (CEDAW), adopted by the UN in 1979, gave States in Article 16 1e) the duty to ensure that women and men had: “The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights.”

The Programme of Action of the 1994 International Conference on Population and Development specifically backed the right of adolescents to reproductive health care. “Information and services should be made available to adolescents that can help them understand their sexuality and protect them from unwanted pregnancies, sexually transmitted diseases and subsequent risk of infertility. This should be combined with the education of young men to respect women’s self-determination and to share responsibility with women in matters of sexuality and reproduction.”

In 1999, The Secretary General reported to a United Nations Special Session on Population and Development that adolescent reproductive health

care needs were still not consistently being met. “In many countries, restrictive laws and regulations impede implementation of the Programme of Action in areas such as sexuality education and adolescent access to reproductive health services. Adolescent reproductive health programmes, where they exist, often lack wide coverage, especially in rural areas; are sometimes too narrowly focused; and often do not engage young people in their design or implementation. Where information, education and communication programmes for young people do exist, they are often not linked to reproductive health services.”

Dr Gro Harlem Brundtland, Director General, WHO, has urged policy makers to overcome any sense of discomfort in addressing these issues, saying: “Young people need adult assistance to deal with the thoughts, feelings and experiences that accompany physical maturity. By providing this help, we are not encouraging irresponsible lifestyles. Evidence from around the world has clearly shown that providing information and building skills on human sexuality and human relationships help avert health problems, and create more mature and responsible attitudes.”

# What health problems do adolescents face?



Adolescents come in all shapes and sizes—being of different ages, sexes, cultures and life experiences. Services for adolescents cannot be provided on the basis of ‘one size fits all’. The health needs of a 10-year-old boy beginning puberty, and an 18-year-old girl who has just given birth are very different. Patterns of health problems differ between and within countries. The rise of HIV infection through injecting drug use is a major concern in Eastern Europe, but not to the same extent in the Western Pacific. Within countries, road traffic accidents or violence may be a significant risk to young people in cities, while malnutrition and malaria may be a greater risk in rural areas.

## Young adolescents

Younger adolescents often lack the means to start to take responsibility for their own health, because they do not properly understand what is happening to their bodies, and may need reassurance and support. Girls may be embarrassed about growing breasts, or embarrassed if they are late developers. Boys too become very anxious about the changes to their bodies. Such concerns are generally transitory, but some young people develop low self-esteem

and depression. Health workers need to become skilled in picking up serious concerns during what may be a short routine consultation.

## Malnutrition

When there is a shortage of food, most families know that they must make special efforts to ensure that babies are well nourished. It is less well understood that adolescent girls and boys have a need for extra nutrition as they grow rapidly and develop and that an inadequate diet can delay or impair healthy development. Stunting can occur in childhood or during adolescence.

In some cultures girls are fed last and fed least. In girls, poor nutrition can delay puberty and lead to the development of a small pelvis. Malnourished adolescent girls who have babies at a young age are more likely to experience, and will be less able to withstand, complications because the body has not yet reached maturity.

Maternal mortality is higher in anaemic women. Even when they survive, poorly nourished adolescent mothers are more likely to give birth to low birth-weight babies, perpetuating a cycle of health problems which pass from one generation to the next.

### General health problems

Adolescents are subject to most of the same illnesses as other age groups within the population. However, they are much less likely to recognise symptoms, and much more likely to underestimate their importance. In addition, they usually do not know where to go for help. As a result adolescents are the least likely section of the population to go for early treatment. They may leave diseases untreated because they are afraid of the outcome, worried about the stigma or do not believe that they will be treated well at a clinic.

Parents actively check the health of children. As adolescents become more independent they take more responsibility for their own health. They must learn when, where and how to seek a check-up or treatment, recognising the early symptoms of malaria, acute respiratory infection or other dangerous conditions.

A survey in South East Nigeria found that 40% of adolescents who use hospital services have malaria. However, two thirds of adolescents with malaria are treated at home or by medicine vendors.

Conditions such as asthma or epilepsy, can be kept under good control with medication. This control may lapse as an adolescent becomes responsible for self-medication.

### Menstrual problems

Girls need support as they begin to menstruate. Without the support of a more knowledgeable person, an adolescent girl may not know what is 'normal' or how to recognise menstrual problems. School health checks, where they exist, often fail to identify difficulties.

### What Wahida never knew about nutrition and pregnancy

Wahida grew up in a traditional village in South East Asia. Food was short and she was expected to let the boys eat first "to keep their strength up". At 12 she was betrothed to a young man ten years older in a neighbouring family.

At 14, she went to live with her husband's family and after a few months of marriage became pregnant. She is excited but nervous about bearing her first child. She wants to be a good wife and mother, but feels exhausted.

There are many things that Wahida does not know. She does not know that she is acutely malnourished. She does not know that from the time her periods started she needed 10% more iron in her diet. She does not understand the word 'anaemic'. She knows that she is on the small side, but not about the strain that childbirth will put on her frail body. She does not know that she and her baby will both die in childbirth.

If Wahida had been in contact with health services, her nutritional status could have been assessed. Perhaps she could have been given iron tablets, or advised to eat more green vegetables.

If Wahida had been able to stay in school she might have been able to delay her marriage. If the needs of young married couples were a higher priority, someone might have discussed the dangers of early childbirth and the benefits of birth spacing with Wahida and her husband. The couple might have discussed contraception.

Antenatal care could have alerted Wahida to the dangers in her pregnancy. If a trained attendant had been present at the birth, Wahida might have been cradling her daughter in her arms, proud and happy, but also determined that in her family, her daughter will get equal shares of food and education.

## Female genital mutilation

It is estimated that 130 million women and girls have undergone female circumcision — female genital mutilation (FGM)—and 2 million girls undergo this procedure each year. FGM is usually practised on young girls from the age of four, but is also carried out on adolescent girls, in some cases prior to marriage. FGM may be done with or without the formal consent of a girl; either way she has no power to challenge a cultural custom. Girls and young women need protection from FGM which has a harmful effect on their sexual health and is an assault on their rights. Alternative non-harmful traditional coming-of-age ceremonies can be encouraged.

## Mental health problems

Mental health problems may first become apparent during adolescence. A young person experiencing depression or another mental health problem has no frame of reference for his or her condition and may not recognise this as an illness or seek treatment.

## Early and unprotected sex

The high number of unwanted pregnancies and unsafe abortions and the steep rise in HIV infection are all evidence that, despite taboos or cultural disapproval, sexual activity in adolescents is more common than official surveys or sources wish to recognise.

Adolescents are disproportionately affected by the risks associated with early and unprotected sex. Many young people become sexually active without planning the sexual relationship or thinking about the consequences. In many cases early sexual experience is unwanted but is the result of coercion or pressure.

Adolescents live in increasingly sexualised societies, exposed to mass media that challenge cultural values. The rapid growth of cities and the breakdown of traditional family structures erode a protective cultural layer. Conflict and forced migration put many young people at risk, sometimes from the very people who are supposed to protect them. In war or extreme economic hardship, girls, and sometimes boys, may be pressured into desperate situations, where they are coerced into sex for survival.

There is a trend towards sexual maturation at an earlier age and, in many societies, a social change towards marriage at a much later age. As a result many young people live for more than 10 years as a sexually mature person before they get married and plan a family. This trend is beneficial if it means that girls do not start having children at too young an age. However, it means that adolescents need to be able to deal with conflicting pressures and expectations without putting themselves or sexual partners at risk. Nor is a forced early marriage a solution, since this takes away choice from a vulnerable

## Autonomy requires dialogue and understanding

Teun lives with his parents in a suburb of a large European city. In childhood he developed epilepsy which disrupted his schooling, but was brought under control by medication he takes twice a day.

When he was 12 he started to become responsible for taking the medication himself. By the age of 15, he had come to hate the pills. He felt that they made him sleepy, made him

‘different’ and were causing mood swings. Without discussing his feelings with a doctor or his parents, he began to take the tablets more and more erratically.

Tuen borrowed a friend’s moped to go to a party. On his way he had a fit and crashed. He has broken his left femur and will be in hospital for a month. Tomorrow the neurologist will talk to Teun about alternative medication.

## What health problems do adolescents face?



*Unprotected sex puts adolescents at risk of pregnancy and sexually transmitted infections.  
Photo: WHO*

young girl, without necessarily putting her at lesser physical risk. Young adolescent married girls have little control over contraception and are expected to take part in unprotected sex at an age when this would meet with strong social disapproval outside marriage. In fact young and vulnerable married girls may be isolated from even the minimal health services offered to unmarried adolescents.

Early marriage resulting in sexual intercourse at a very young age, is sometimes defended on the grounds that it is a traditional cultural custom. The same defence is sometimes made of FGM. While it is important for health services to be sensitive to cultural customs, this cannot be at the cost of damaging the health and well-

In parts of sub-Saharan Africa almost half of girls are pregnant by the age of 19, and adolescent girls make up almost half of those having abortions. The majority of people newly infected with HIV are aged from 15-24 years. Girls are five times more likely than boys of their age to become infected.

being of vulnerable young people. The Convention on the Rights of the Child, the most widely adopted Convention in the world, is clear on this point. Article 24, which gives children and adolescents a right to health care says in Clause 3:

“States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.”

Girls who become pregnant under the age of 18 are between two and five times more likely to die in childbirth than older women.

The legacy of unsafe and unprotected sex is also seen in the number of adolescent girls who undergo abortions both outside or within marriage. Many pregnancies are terminated at great risk to the young women, including pelvic infection, infertility or even death. Safe abortion services are needed because, where they are not provided, girls seek unsafe illegal abortions which put their health and lives at risk. It is believed that the majority of abortions for adolescents are carried out by unskilled staff in dangerous conditions. Because adolescent girls are reluctant to give information about

## Early and unprotected sex within marriage

Anjali lives in Shevali village in the Dhule District of Maharashtra in Western India. At the age of 15 she was betrothed to the second son of a neighbour, Pramod, who is nearly ten years older than she is and who works in a machine tool factory in Mumbai.

When she was just 16 they were married. Anjali thinks it is much too soon to want a baby, but she does not know how to find out about contraceptives, and when she asked her husband he said: "It is never too soon to start bearing me sons." They have unprotected sex whenever he is home from Mumbai, about every three months.

In Mumbai Pramod shares one room with four other men, one of them his cousin. He feels

frustrated and sex on his visits home seems hurried. He feels that Anjali does not enjoy it but does not know how to talk to her.

One of his work mates took him to a brothel, and now every three weeks or so Pramod finds himself heading in that direction. Sex is sordid. He hardly sees the face of the girl, and it is all over in minutes. He does not use a condom.

He was last home a month ago, and he is again feeling frustrated. Meanwhile Anjali is going out of her mind with worry. She has had itching and now has a discharge. She does not know who to ask and she is terrified of what is happening to her. She has done nothing wrong, but she feels guilty and dirty. She is seeking the courage to ask Pramod's married sister who lives nearby.

abortions, and even young married girls who undergo abortion may keep it secret from their husbands and close family members, it is difficult to collect accurate data. Estimates for adolescent abortions vary from one million to four million a year.

Abstaining from sex, delaying the onset of first sexual experience, reducing the number of sexual partners and increasing levels of protection through condom use are all ways to reduce unwanted pregnancies and sexually transmitted infections. Many adolescents never have an opportunity to discuss these issues with a caring adult, while services which could protect them are not widely available.

Sexually transmitted infections affect one in 20 young people every year, and although most are curable, many infections are left untreated. HIV/AIDS is a worldwide pandemic which affects young people disproportionately. Across the world every day around 7,000 young people are infected with HIV, a significant threat to this generation and to the economic prospects of affected countries.

## Addictive behaviours

The biggest threat to the lives, health and well-being of young people are the activities they may adopt during their adolescent years when a complex mesh of harmful practices and risk factors puts them in peril. Addictive behaviour is often referred to as 'risk behaviour', but it is a risk that adolescents are not good at assessing, since they do not understand the long-term consequences of adopting what they may regard as being only a temporary habit.

Alcohol and drug use are risk behaviours in their own right and because they also reduce caution and judgement they expose the user to other risks. Much activity is experimental and many adolescents pass through such a period unscathed. For a small proportion of adolescents even occasional use results in a disaster, while others are drawn into heavy use leading to long term problems. Regular alcohol or drug use can appear to be a way out for a young person who sees no positive solutions, but it is usually a way into more serious problems. Habits that are expensive and illegal make it more likely that

### Florence was pressured into having sex

Florence is 16 and lives with her family in a village in East Africa. She has done well at school and her mother has encouraged her to stay on - provided she also works to help to meet the school fees. Florence got an after-school job cleaning up and serving at a nearby roadside café.

After a few weeks, the owner, who is old enough to be her father, made it clear that she was expected to provide extra services if she wanted to keep her job. Reluctantly, Florence had sex with him each week before going home.

Florence became pregnant and consulted a friend about what to do. She took her savings to a woman in the next village who said she could help. After an excruciating procedure to abort, Florence has been in pain, and a week later she still has bleeding. She fears that she will never be able to have a baby.

She would like to go to the clinic, but a friend of her mother works there and she fears that word would reach her home. Florence has stopped sleeping at nights. She wants to tell her mother but does not know how.

adolescents will be drawn into crime, while research shows that a young person who adopts one risky practice is more likely to adopt another.

The addictive behaviour most common amongst adolescents is cigarette smoking. WHO estimates that 500 million people who are alive today will eventually die of smoking related diseases including cancers, heart disease and respiratory diseases.

Almost all regular smokers take up the habit by the age of 18, and half of the 150 million adolescents who continue to smoke will

eventually be killed by tobacco related conditions.

As efforts to reduce smoking and tobacco use in Europe and North America show some success, tobacco companies increasingly aim to recruit new smokers from developing countries. As a result, worldwide mortality from smoking related diseases is expected to rise to 10 million deaths a year by 2030, more than the total of deaths from malaria, maternal and major childhood conditions and tuberculosis combined. Over 70% of these deaths will be in the developing world.



*Injecting drug users put themselves at risk, especially when sharing needles.  
Photo: WHO*

Most smoking related deaths occur between the ages of 35 and 69, and each smoker loses an average of 20-25 years life. Most smokers begin during adolescence — when they have incomplete information about the risks of tobacco and its addictive nature, which has been compared by some experts to the potency of dependence induced by heroine or cocaine.

The tobacco industry misrepresents efforts by WHO, UNICEF and others to protect young people as attacking their freedom to smoke and as imposing a ‘first world’ agenda onto developing countries. However, the impact of the future patterns of disease on health services will overwhelming affect the developing world.

The tobacco industry targets adolescents through promoting cigarettes as ‘cool’ and associating smoking with independence. For adolescent boys and girls, what starts as a gesture of independence quickly becomes addictive dependence. In Asia the promotion of cigarettes increasingly targets adolescent girls. In some European countries more young women now smoke than young men.

The most effective measures prevent adolescents from taking up smoking in the first place. They include bans on tobacco advertising, increasing the price of tobacco products through taxation and creating smoke-free areas at schools, colleges, health facilities and sporting venues. Tobacco taxes have their greatest impact on young smokers.



*Young adolescents are attracted to smoking without understanding the impact it will have on their lives. Photo: WHO*

## Accidents and violence

Deaths and injuries from accidents are more likely at this age than any other. Unintentional injury is the leading cause of death amongst young people in many countries, with road traffic accidents a constant threat in urban areas. Boys are particularly vulnerable to injury from accidents throughout adolescence.

Young men are vulnerable both as victims and perpetrators of violence. Adolescent males who are beginning to seek their place in society often believe that they have to demonstrate physical courage and not back down. Confrontations

## Injecting drugs a high risk for HIV and AIDS

Vesna is 19 and lives in what used to be part of the former Soviet Union. He left school at 16 and got a job in a nearby factory. The factory closed down after six months, and Vesna has not had a full time job since then.

He started drinking heavily, and in a club he met some people who introduced him to drugs, which seemed to make things better for a while. While he was ‘high’ he did not need to think

about the future. Vesna has been injecting drugs for a year.

A friend advised him to go for an AIDS test, and Vesna must now tell his girl-friend that he has become infected with HIV through injecting heroin using dirty needles. He cannot see any point in carrying on. He finds himself thinking about killing himself. Sometimes it seems his only way out.



*Girls who had been abducted by a rebel army in Northern Uganda celebrate their freedom at a rehabilitation centre in Northern Uganda. Adolescents caught up by violence are often sexually abused. Photo: World Vision*

between young males with an audience, often leave participants with no easy way out. Young males are often afraid in such situations, but lack skills at defusing tension and get into fights that they did not want to have. One-to-one fights with bare hands do not usually result in serious injury. However, young men in gangs are more likely to use weapons, transforming a pride bruising fist fight, into a potentially fatal encounter with a knife or gun.

Violence within the home is not fully acknowledged and children may be at risk from violent parents well into adolescence. Young married women may be physically abused by their husband or by their in-laws. In many cultures 'domestic' violence is not treated seriously by police and courts. Young women are especially vulnerable to sexual violence.

### *Sexual abuse*

For millions of adolescents, sex is linked with coercion, violence and abuse – sometimes even by family members or adults with privileged access. In many societies, women are conditioned to be submissive to men, and they find it difficult or impossible to refuse early marriage, to space births, or to refuse to have

unprotected sex with an unfaithful partner.

Across the world, a huge number of children and adolescents are abused sexually. Most at risk are girls, aged 11-16, but boys are at risk too. Young women are especially vulnerable to force or threats and to psychological pressure. Sexual abuse rarely takes place in isolation from other forms of oppression. Abuse is mainly about a power relationship and young people have little power. The Convention on the Rights of the Child gives children and adolescents the right to be protected against all forms of sexual exploitation and abuse, but that right is in practice conditional on adults respecting and enforcing it.

Much sexual abuse takes place in the home and is never reported or revealed. But young people are especially vulnerable when they are unprotected by families. Adolescents who are homeless, perhaps living on city streets, and adolescents who are displaced from their homes by conflict or by natural disaster are at high risk. Young women may trade sex for the protection of their families, or for essential material goods to keep their families alive. In the case of refugees, there is evidence that some sexual exploitation is by soldiers acting as peacekeepers



*AIDS leaves many young people as orphans at a time when they most need parental support. Photo: WHO*

or by workers employed by international agencies. Children in all institutions are at risk, including adolescents in prison, and adolescents with disabilities in institutional care.

There is an increasing world trade in the sexual exploitation of young people, usually girls but also boys. This includes 'sex tourism' and organised child abuse including child prostitution and child pornography. UNICEF estimates that a million children and adolescents a year are recruited into the commercial sex trade. There is a high demand for children aged 12-16, and this market is growing wherever tourism operates or economies grow and men have money to spend. The UN has ratified an Optional Protocol to the CRC to confront the trafficking of children.

### *Depression and suicide*

Mental health problems frequently start to make themselves felt in this age group. Depression is common, especially for young people who have low self-esteem. They may feel that they have no future or are 'useless'. Depression reduces the quality of a young person's life at a time when he or she should be full of optimism and hope. A young person who sees no future is more likely to take risks with his or her health. Depression can also lead to the ultimate tragedy — almost 90,000 young people commit suicide each year across the world.

### *Eating disorders*

In a growing number of developing countries, obesity and eating disorders exist alongside malnutrition. From an early age adolescents are under pressure from mass media to conform to ultra thin body shapes and have a poor self image as a result. To doctors and nurses used to dealing with malnutrition, the problems of obesity or anorexia may seem trivial. They are not trivial to adolescents who grow up learning to hate their bodies and themselves. In extreme cases eating disorders such as bulimia and anorexia can permanently damage physical and mental health.

Obesity itself is a major problem in some societies. A failure to deal with this at a young age, can lead to a lifetime of poor health and unhappiness and an early death ■

### Summary

- **Adolescents are subject to many of the same diseases as children and adults. There are also some health risks that are especially connected with puberty.**
- **Adolescents have different health risks and needs according to their age, sex and living circumstances.**
- **Adolescents may not appreciate the importance of seeking treatment when they are unwell, and often underestimate the severity of their condition.**
- **Adolescents are vulnerable to harmful consequences of health risks. Some, like depression or interpersonal violence, have immediate effects, while others such as sexually transmitted infections or smoking have harmful or fatal effects in the medium or long term.**
- **Adolescents, especially girls, are vulnerable to sexual abuse.**

# What health services do adolescents need?



Adolescents have in many surveys expressed their views about what they want from health services. They want a welcoming facility, where they can 'drop in' and be attended to quickly. They insist on privacy and confidentiality, and do not want to have to seek parental permission to attend. They want a service in a convenient place at a convenient time that is free or at least affordable. They want staff to treat them with respect, not judge them. They want a range of services, and not to be asked to come back or referred elsewhere. Of course, those who plan and provide services cannot only think about the wishes of adolescents — services must be appropriate and effective, and they must be affordable and acceptable for the community too. (A full list of characteristics for adolescent friendly health services can be seen in a box on Page 27). However, services for this age group must demonstrate relevance to the needs and wishes of young people.

Health services play a critical role in the development of adolescents when they:

- treat conditions that give rise to ill health or cause adolescents concern;
- prevent and respond to health problems that can end young lives or result in chronic ill health or disability;
- support young people who are looking for a route to good health, by monitoring progress and addressing concerns;
- interact with adolescents at times of concern or crisis, when they are looking for a way out of their problems;
- make links with other services, such as counselling services, which can support adolescents.

Young people in crisis need counselling and community support beyond what health services alone can offer. This support comes from parents, families, teachers, trained counsellors, religious or youth leaders and other adults and from their own peers. However, if these links break down, early signs of crisis may become apparent during contact with health services.

Health care staff need to be sensitive to signs of anxiety, and know how to deal with young

people in crisis, or where to refer them. Services also need to include information and education to help adolescents to become active participants in their own health.

Programmes monitoring growth and development should provide a golden opportunity for adolescents to request help and for health care staff to give them information. However, such programmes are rarely provided at school and even when health checks do take place, they seldom give young people this kind of opening.

### Essential services

Is it possible to define essential health services for adolescents? A regional consultation carried out by the Pan American Health Organization suggested that a core package for improving adolescent health and development should:

- monitor growth and development;
- identify and assess problems and problem behaviour, managing these where possible or referring young people if they cannot;
- offer information and counselling on developmental changes, personal care and ways of seeking help;
- provide immunisation. (Immunisation programmes are run for young children but not for an older sister or brother. Adolescent girls need protection from rubella before they become pregnant. Vaccines are also available for meningitis, hepatitis and tetanus.)

A WHO consultation in Africa in October 2000 agreed that “adolescents have a right to access health services that can protect them from HIV/AIDS and from other threats to their health and well-being, and that these services should be made adolescent friendly”. The consultation recognised that health and development needs cannot be met by health services alone, but outlined an essential list of clinical services:

- general health services for tuberculosis, malaria, endemic diseases, injuries, accidents and dental care;



*Young people need a safe and supportive environment, information and skills, and health services and counselling.*  
Photo: WHO, Geneva

- reproductive health including contraceptives, STI treatment, pregnancy care and post-abortion management;
- counselling and testing for HIV, which should be voluntary and confidential;
- management of sexual violence;
- mental health services, including services to address the use of tobacco, alcohol and drugs;
- information and counselling on development during adolescence, including reproductive health, nutrition, hygiene, sexuality and substance use.

However, an appropriate range of essential services must be decided by each country, based on local needs assessments.

The Global Consultation on Adolescent Friendly Health Services held by WHO in Geneva in March 2001, concluded that a core package could not be a ‘fixed menu’. Instead, the Global Consultation suggested that each country must develop its own package, negotiating its way through economic, epidemiological and social constraints, including cultural sensitivities. It declared: “What is needed is a process by which government ministries can make decisions about what is most appropriate

for their situation, taking into account cost, epidemiological factors and adolescent development priorities.”

To take one example, South Africa has developed a package of essential adolescent health care services at a primary level, focused on reproductive health — HIV, STIs, pregnancy — and on violence, which is often sexual in nature. It advocates including counselling, contraceptives, pregnancy tests and HIV testing at primary care level, and that abortions should remain legal. This South African package focuses on the priority issues for young people and develops an approach that is culturally acceptable to most people. Another country might develop a different set of priorities, or a different method of working. ■

### Knowledge and treatment go hand in hand

In Bangladesh, the NGO Jatiya Taruh Sanga worked with WHO and the World Assembly of Youth to improve the nutritional health of young women, through a combination of nutritional supplements and health education. The aim was to reduce maternal mortality and morbidity in a society where almost half of young women are mothers by the age of 17.

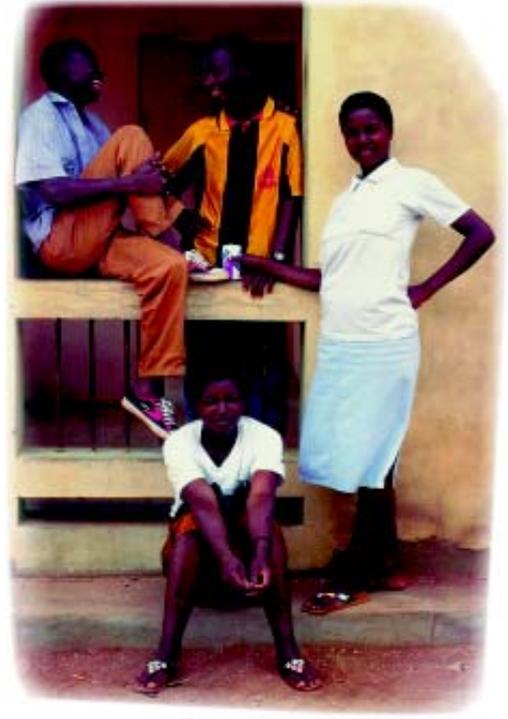
About 8,000 women aged 15-20 were targeted in campaigns that combined giving the young women iron and folic acid supplements but also providing them with nutrition education.

At the end of four months the NGO noted an increase in the height and weight of the women taking part. They believe that the women were more willing to accept the health intervention and to keep taking the iron and folic acid, because they understood from the health education that the supplements were beneficial.

### Summary

- Health services can help to meet adolescent needs, only if they are part of a comprehensive programme. Adolescents need:
  - A safe and supportive environment that offers protection and opportunities for development,
  - Information and skills to understand and interact with the world,
  - Health services and counselling — to address their health problems and deal with personal difficulties.
- Health care providers cannot meet all these needs alone. They can join or create networks that act together and maximise resources.
- A package of basic health services must be tailored to local needs, including growth and development monitoring and immunisation.
- Reproductive health services, counselling and voluntary testing for HIV and other sexually transmitted infections are a high priority in some places.
- Mental health services and counselling are important elements to support adolescents. Health services are only part of the answer — there is a need for support from caring adults.
- There is no single ‘fixed menu’ suitable for every country. Each country must develop its own package, according to economic, epidemiological and social circumstances.

# Do existing services meet the needs of adolescents?



**S**urveys in many countries suggest that when young people are looking for urgent treatment for what they consider to be sensitive conditions, public sector health services are often their last resort. Health service providers are often dismayed by these findings, as they want to be a resource for young people — but they do not know how. Yet adolescents can be excluded by poor service delivery or their own lack of awareness, a combination of legal, physical, economic and psychological barriers.

- **Lack of knowledge on the part of the adolescent**

Most young people do not have the knowledge or experience to distinguish between conditions that go away of their own accord and those that need treatment. They do not understand their symptoms or the degree of risk they may be taking. They do not know what health services exist to help them, or how to access them.

- **Legal or cultural restrictions**

Reproductive health services, such as family planning clinics or abortion services, are often restricted. Abortions may be illegal, although the health system deals with the consequences of unsafe abortions. Even if condoms are available, health workers may hold them back from

adolescents. Young people need consent from their parents for medical treatment.

- **Physical or logistical restrictions**

Services may be a long way from where the young person lives, studies or works, or available only at inconvenient hours. Some services may be inaccessible to the general public — for example, it may only be possible to access a drug treatment programme via the criminal justice system.

- **Poor quality of clinical services**

Quality may be poor because health care providers are poorly trained or motivated, or because a health facility has run out of medicines or supplies.

- **Unwelcoming services**

Of special concern is the way in which services are delivered. Young people are very sensitive to privacy and confidentiality, and do not want their dignity to be stripped away. Adolescents are more likely than older people to be deterred by long waiting times and administrative procedures, especially if they are made to feel unwelcome. Unfriendly health care providers who do not listen or are judgmental, make it difficult for young people to reveal concerns. They may not return for follow up care.

## The nurse who prescribed blame for young patients

Dr Kaya, a specialist in reproductive health at a city hospital, is on secondment at a rural health centre 200 kilometres away. She is travelling with an outreach worker as part of a Ministry of Health quality improvement programme. Her task is to observe the work and to identify the needs for staff, equipment and training.

Dr Kaya is with the nurse, a woman in her late 30s who has a reputation for being forceful and energetic. Dr Kaya is impressed with the efficient way she keeps the patients flowing. Her brusque manner is probably a result of the pressure.

The next patient, a girl of 16, stares at the ground and says in a hardly audible voice, that she hurt herself 'down there'. She shows the nurse sores around her vagina and says she has been having a discharge. This is clearly a sexually transmitted infection and the nurse tells her so loudly, so that her voice carries to the queue still waiting in the corridor outside.

The girl utters something inaudible. "Don't tell me you did it just once," says the nurse. "That's what you all say. You got this from a man who

has been sleeping around." All this time she is giving the girl an injection and making up a package of pills. She gives her instructions on how to take the pills, although it seems to Dr Kaya the girl is not listening, but wishing she was somewhere else.

As the girl stands up to leave, the nurse stands in front of her and waves her finger. "Listen to me. When an unmarried girl has sex it is a sin. When she has sex with a married man, the disease is her punishment. Next time it could be worse — you could get AIDS and die. It will be your fault."

The girl leaves weeping and clutching her medicine, and the nurse glares at the doctor. "I can see you think I am being a bit hard," she says. "That's how it is with these up-country girls who have no morals. I have to scare them — and it works," she says defiantly.

"How do you know it works?" Dr Kaya asks gently.

"Because they never come back," says the nurse, triumphantly.

### ● High cost

Young people usually cannot afford to pay for health services but must ask an adult to support them. When desperate, young people will 'beg, borrow or steal' money for treatment, but may then seek help in the private sector so as to protect their privacy, even if this treatment is more expensive and less effective.

### ● Cultural barriers

In many countries a culture of shame discourages adults and children from talking about their bodies or sexual activity. This can inhibit parents from discussing sensitive issues with their children, and make a young person reluctant to use sexual or reproductive health services. It may also be difficult to seek help after violence and sexual abuse within the

family. Not every adolescent has the same concerns and not all services are equally sensitive, but these factors are widely applicable across cultures, for both sexes and especially among adolescents who have low self-esteem or who feel vulnerable.

### ● Gender barriers

Some barriers are especially associated with the gender of the young person. Adolescent girls are very reluctant to be examined by males, while young men may find it difficult to discuss intimate symptoms with a female health care provider.

The sensitivities recorded above may be especially powerful disincentives for girls to use services. There are many cultural barriers associated with gender. It takes two to make a



*Young people seeking health care want skilled providers who are friendly, sympathetic and who maintain confidentiality.  
Photo: WHO*

baby, but it is girls who become pregnant. It is very difficult for a 16-year-old girl to attend a local clinic for a pregnancy test or for contraception, if she knows that she will be seen by a relative or neighbour. Girls who do not leave the house much may have less access to information and in some cultures have to seek consent from a parent or spouse before treatment. Girls may even be denied treatment by health workers, despite being legally entitled to them.

### *Peer pressure*

Adolescents often consult their friends about where they should seek treatment, and in this way, one person's experience becomes the criteria by which a group of young people make their health care decisions. Some may seek out useful sources of help such as trained pharmacists, but others turn to street vendors, or unlicensed practitioners. Many seek no treatment at all with potentially catastrophic results.

This reluctance to seek early help goes beyond reproductive and sexual health matters. The Chest Clinic in Korle-Bu Teaching Hospital in Accra, Ghana, identified problems in diagnosing

### Why adolescents delay seeking treatment

The Women's Health and Action Research Centre in Nigeria found a tendency amongst adolescents experiencing STI symptoms to delay treatment. They sought help from untrained patent medicine dealers and, if this failed, from private doctors or traditional healers. Factors associated with poor or late use of services were:

- cost,
- lack of confidentiality,
- being made to feel guilty,
- long waiting times,
- poor levels of treatment effectiveness.

M Bello, from the Adolescent Health and Information Project, told the WHO regional consultation that some people put their faith in prayer rather than seek medical attention. "The belief that no medicine can work better than prayers has led a lot of young people to believe that they can depend on their prayers and hide their uncomfortable feelings about seeking health care."

and treating TB in street children and in young people in boarding schools and colleges. Street children presented late and usually did not complete their treatment, although they represented a significant source of hidden illness and infection.

Young people in boarding schools or colleges also presented late because they wanted to hide the diagnosis from their peers, the school authorities and their families. In both cases, the adolescents were protecting their privacy above their need for medical care. This resulted in poor treatment, missed classes and an inability on the part of the hospital to provide effective contact tracing. When young people are confident that hospitals and clinics protect confidentiality, they ask for help sooner. ■

### Summary

- **Adolescents lack knowledge about what services are available and how to access them.**
- **There may be legal restrictions on the use of services or cultural reasons why young people do not wish to be seen there.**
- **Adolescents give high priority to confidentiality. This may be more important than seeking treatment.**
- **They are put off if the services are a long way away or are expensive.**
- **They will not use unfriendly services or those with poorly trained staff.**

### Young people put off by high fees and lack of privacy

**Côte D'Ivoire** is one of seven countries in French speaking sub Saharan Africa taking part in a WHO supported initiative to improve reproductive health services for adolescents.

In 1998 the research programme surveyed more than 2,200 adolescents in urban and rural areas and analysed 2,400 visits to health facilities. Discussions were held with groups of parents, adolescents and health staff.

Young people reported that most visits (72.7%) were for common health problems such as malaria, skin problems, diarrhoea or headache. Health workers said that adolescents mainly accessed services for STI or HIV/AIDS testing, pregnancy testing or contraception. The registers showed that a quarter (23.7%) of total consultations were by adolescents, but that they accounted for half (49%) of antenatal care visits and more than half (56%) of deliveries.

The study identified that adolescents did not use services if they judged health workers to be judgmental or rude or believed that traditional remedies cost less and were more effective.

Of those who attended clinics, more than a

quarter (28.4%) had hesitated a long time, 41% thought fees were too high, 22% did not feel comfortable during consultation, 36% were unable to achieve privacy and 46% felt unable to ask all the questions they wanted to ask.

The conclusion was that the project should train staff, modify existing services to become adolescent friendly and provide better information.

A baseline study in **Senegal** showed that 98% of adolescents wanted more information about reproductive health and about services, but that parents were reluctant to discuss sexual matters with their children, especially contraception.

A baseline study in **Guinea** revealed that 88% of adolescents had had their first sexual experience before the age of 17, but that few knew how to access information or services. Adolescents were five times more likely to attend a health centre for a pregnancy test than for contraception. Obstacles to using services ranged from long waiting times and inconvenient hours to fear of revealing sexual activity.

# What makes health services 'adolescent friendly'?



**A**dolescent friendly health services represent an approach which brings together the qualities that young people demand, with the high standards that have to be achieved in the best public services. Such services are accessible, acceptable and appropriate for adolescents. They are in the right place at the right time at the right price (free where necessary) and delivered in the right style to be acceptable to young people. They are equitable because they are inclusive and do not discriminate against any sector of this young clientele on grounds of gender, ethnicity, religion, disability, social status or any other reason. Indeed they reach out to those who are most vulnerable and those who lack services. The services are comprehensive in that they deliver an essential package of services to the whole target group.

They are effective because they are delivered by trained and motivated health care providers who are technically competent, and who know how to communicate with young people without being patronising or judgmental. These providers are backed up by adolescent friendly support staff and have access to equipment, supplies and basic

services. They also maintain a system of quality improvement so that staff are supported and re-motivated to keep up their high standards. Finally the services are efficient so that they do not waste money, and they record enough information to be able to monitor and improve performance.

The gold standard for adolescent friendly health services is that they are effective, safe and affordable, they meet the individual needs of young people who return when they need to and recommend these services to friends.

Even if this ideal cannot be achieved immediately, improvements bring results.

Making services adolescent friendly is not primarily about setting up separate dedicated services, although the style of some facilities may change. The greatest benefit comes from improving generic health services in local communities and by improving the competencies of health care providers to deal effectively with adolescents.

The characteristics of adolescent friendly health services were discussed during the global consultation process initiated by WHO in 2000, and continued during the discussions by the

expert group convened by WHO in Geneva in 2001. A detailed list of characteristics based on these discussions are summarised in the box on the facing page. These characteristics are intended for application sensitively in each country, bearing in mind the cultural, social, economic and political context and the need to support health care providers to deliver the best possible service to adolescents.

A more detailed exposition of the characteristics is included in the resource document, *Adolescent Friendly Health Services, Making it Happen*, being published by WHO as a companion volume to this in 2002. This section looks more closely at some of the concepts.

### Technical competence

Doctors and nurses need a good knowledge of normal adolescent development and the skills to diagnose and treat common conditions, such as anaemia or menstrual disorders in adolescent girls, and to recognise signs of sexual or physical abuse. They need access to the correct drugs and supplies to treat common conditions and prevent health problems. They should know where to refer adolescents for specialist physical or psychological treatment. Such referrals may be to people or services outside the health system for counselling or social support.

### See the person, not the problem

Technical competence must be accompanied by respect and sensitivity to draw the young person out and to discover underlying problems that may not be the immediate cause of a visit. As well as conditions that only a clinician can understand, such as a 'suboptimal adolescent growth spurt', a doctor, medical officer or nurse must be able to recognise a young person who is confused or frightened. Adolescents often lack confidence and may present with a 'safe' symptom, to test the service before revealing their real concerns. By focusing on the person, rather than the symptom, providers can discover underlying concerns. Technical skills and a sympathetic professional approach should be combined with a non-judgmental approach. Health care providers do not need to abandon their own belief systems or values, but they do need to understand a situation from an adolescent's point of view and not to allow their own views to dominate the interaction.

### Training and staff support

Technically competent and empathetic staff need a system of ongoing support. An adolescent friendly approach should include repeated

### Ten minutes to promote responsible sex

A nurse-midwife in a district hospital is holding her weekly antenatal outpatient clinic. Amongst those waiting are two young women in their late teens. One of the students is crying; the other is comforting her.

The women are students at the technical college. One is three weeks late with her period and believes she is pregnant. Gentle questioning reveals that she has a boyfriend at college. She says they had 'gone too far'. Now she will have to leave her course and will be disgraced. She bursts into tears.

The nurse midwife understands the young

woman has had unprotected intercourse. She carries out an examination and orders a urine test. She cannot counsel the young student while she is waiting for the result, so she asks her to wait. An hour later she is able to tell the student that the test is negative. The student sobs with relief.

It is time for the clinic to close, but the midwife nurse wants to stay another ten minutes. She sits the girls down. "If I can interrupt your joy," she says with a smile, "I think we should have a little chat about how you can make sure you do not need to return to this clinic."

## Characteristics of adolescent friendly health services

**Adolescent friendly health services need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient.** These characteristics are based on the WHO Global Consultation in 2001 and discussions at a WHO expert advisory group in Geneva in 2002. They require:

- 1 Adolescent friendly policies** that
  - fulfil the rights of adolescents as outlined in the UN Convention on the Rights of the Child and other instruments and declarations,
  - take into account the special needs of different sectors of the population, including vulnerable and under-served groups,
  - do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age,
  - pay special attention to gender factors,
  - guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care,
  - ensure that services are either free or affordable by adolescents.
- 2 Adolescent friendly procedures** to facilitate
  - easy and confidential registration of patients, and retrieval and storage of records,
  - short waiting times and (where necessary) swift referral,
  - consultation with or without an appointment.
- 3 Adolescent friendly health care providers** who
  - are technically competent in adolescent specific areas, and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances,
  - have interpersonal and communication skills,
  - are motivated and supported,
  - are non-judgmental and considerate, easy to relate to and trustworthy,
  - devote adequate time to clients or patients,
  - act in the best interests of their clients,
  - treat all clients with equal care and respect,
  - provide information and support to enable each adolescent to make the right free choices for his or her unique needs.
- 4 Adolescent friendly support staff** who are
  - understanding and considerate, treating each adolescent client with equal care and respect,
  - competent, motivated and well supported.
- 5 Adolescent friendly health facilities** that
  - provide a safe environment at a convenient location with an appealing ambience,
  - have convenient working hours,
  - offer privacy and avoid stigma,
  - provide information and education material.
- 6 Adolescent involvement**, so that they are
  - well informed about services and their rights,
  - encouraged to respect the rights of others,
  - involved in service assessment and provision.
- 7 Community involvement and dialogue** to
  - promote the value of health services, and
  - encourage parental and community support.
- 8 Community based, outreach and peer-to-peer** services to increase coverage and accessibility.
- 9 Appropriate and comprehensive services** that
  - address each adolescent's physical, social and psychological health and development needs,
  - provide a comprehensive package of health care and referral to other relevant services,
  - do not carry out unnecessary procedures.
- 10 Effective health services for adolescents**
  - that are guided by evidence-based protocols and guidelines,
  - having equipment, supplies and basic services necessary to deliver the essential care package,
  - having a process of quality improvement to create and maintain a culture of staff support.
- 11 Efficient services** which have
  - a management information system including information on the cost of resources,
  - a system to make use of this information.

training sessions to refresh the skills of current staff as well as developing new skills for new staff. Training and peer-review sessions should cover everyone from doctors (who may believe they need no further training) to the receptionist and cleaner, who may be surprised that they are part of the team. These staff may be the first person an adolescent meets at a health facility. If they are unfriendly, or indiscrete an adolescent may never return.

Management and supervision should be aimed at creating a supportive environment and at developing systems to maintain and improve quality. Health care providers should be involved in drawing up protocols and guidelines covering key quality issues. They should also develop self-assessment and peer review mechanisms which create a culture of openness. Monitoring systems should encourage adolescents to provide feedback on services.

### *Making the service physically accessible*

Services need to be provided in places that adolescents can reach, at times that they can get there. This may involve holding special clinics in youth centres, or other places where adolescents go. Clinical staff can take turns to do late duty rotas so that a clinic can run in the evening or at weekends, when young people are not at school, college or working.

Physical surroundings are important. Many places have no special adolescent centre, but still provide a welcoming health facility. Attention can be paid to the paintwork, posters on the walls, cleanliness and whether there are enough chairs where people wait. A general adolescent health clinic can advertise its name at the entrance, while an STI clinic may want a discrete entrance. Adolescents themselves may help to decide on a creative name that will be welcoming but not stigmatising. A busy city hospital with little money for capital development can create an 'adolescent health corner', by putting up a partition, so that young

people can be seen in privacy, or by using a rear door where they can enter without stigma.

Some clinics give young people numbers when they arrive so that they can be called to see the doctor or nurse without having to sit in a queue 'on display' and without having their name called out. While waiting they should be able to look at health promotion literature, or even view a video.

### *Confidentiality and privacy*

Adolescents need to be assured of privacy during a consultation and confidentiality afterwards. Young people should not be expected to undress or be examined where people can see them. Those waiting outside should not be able to hear a doctor giving a diagnosis. Patients must be confident that medical records will not be left on view and that receptionists will not gossip.

There is in most countries a legal obligation for doctors to report sexual assault, a road traffic accident or gunshot wounds. There are also legal restrictions on treatment to young people below a certain age without parental consent. These and other legal constraints need to be explained as the only exceptions to a strict policy of confidentiality. This policy itself can be jointly developed with adolescents and health care providers so that everyone understands and feels comfortable with the ground rules. The confidentiality policy, including exceptions, needs to be explained to all adolescent users and to parents or guardians, and needs to be clearly understood by referral agencies.

### *Services that are acceptable to the local community*

Simply making services 'adolescent friendly' will not increase usage, unless young people feel that it is acceptable to be seen to use them.

Community support for the service must also be sought. The community should have an opportunity to understand why services are important for adolescents, and why these should include sexual and reproductive health services

and confidential counselling. Local meetings may be held for parents, and community and religious leaders should be approached for support. Services may even be located in community settings. There are many examples of services being delivered in schools, community centres or on the street.

Where public support is difficult to achieve (as is often the case for health services for sex workers or for injecting drug users) the services can be run in a low key way, or through community outreach workers.

### *Involving adolescents*

Services that reach a high quality are those that closely involve adolescents in their planning and monitoring. Through the involvement of young people service providers can be confident that they are providing services in the right place, at the right time and in the right style. The involvement of adolescents in planning and monitoring delivers on their right to have their views heard. It also increases the confidence that other young people place in those services. ■

### Summary (see also box on page 27)

- **Adolescent friendly health services have high clinical standards and the qualities that young people seek.**
- **Services are accessible, acceptable and appropriate — in the right place at the right time, and affordable.**
- **They are equitable, inclusive and do not discriminate. They reach people who are vulnerable or lack services.**
- **They are comprehensive, delivering an essential package of services.**
- **They are effective — delivered by competent and motivated providers who know how to communicate.**
- **Equipment & supplies are in place.**
- **A system of quality improvement supports and motivates staff.**
- **Services are efficient and record information to monitor performance.**
- **Services involve adolescents in planning and monitoring. They aim to be acceptable to the community.**

## 'You have to build trust before young people will open up'

Josephine is a nurse at the World Vision Centre in Gulu, Northern Uganda, where young people who have been abducted by a rebel army are treated and given counselling on their return home. Many have illnesses or injuries that are not healing, including gun shot wounds or sexually transmitted infections. Some of the girls are pregnant.

Josephine arranges a full physical check up and hospital treatment for those who need it but knows that these young people will never heal unless she and her colleagues address the psychological scarring.

"They used to bring them straight here undernourished, tired, weary and with no hope at all. They looked scared. They are not sure

what comes next. We make them feel free and we share the love and care and then you will see the change in them, especially when the army is not around."

Florence, an outreach co-ordinator at the centre, says: "It is important to build rapport and a relationship with the person. They don't trust anybody. The first time that a child tells you a story she does not tell the whole truth. It is not until after much talking she will tell you about being given to a man or being forced to go with a man. When you show them love, and you open yourself up for them, they open up. They want to be sure that you will keep what they tell you private. Otherwise the next time they would not tell you a thing."

# How are services best delivered to adolescents?



**A**dolescent friendly health services can be delivered in hospitals at health centres, in schools, or in community settings. They may be planned from above or started by groups of dedicated health care professionals who see that the needs of adolescents are not being met, and who believe that services can be more effective. This section gives examples in a range of different settings.

- **Services at health centres or hospitals**

Basic health services are usually delivered at ordinary health centres in local communities and there is no reason why this should not also meet the needs for many adolescents. One important task is to train and support staff in this setting, to improve skills and to develop an empathetic approach, so that young people are willing to attend. These skills can be sustained through regular post qualification training, and through a system of clinical protocols and guidelines, together with peer assessment and good quality supervision and management.

Privacy may be improved by holding special sessions outside normal opening hours, by creating a separate entrance for young people or by improving confidentiality once inside. A

number of hospitals have developed specialist adolescent services or clinics in outhouses or as part of the main building. Hospital based services have skilled specialists on site and can offer a full range of medical services. However, they are limited to centres of population, and may be constrained by competing demands for funds.

There are also dedicated health centres which provide a full range of services especially for adolescents. Such centres may be in large towns or cities, where they are relatively cost effective, or they may be run by NGOs as 'beacon' services that show what can be done. Such services can provide training and inspiration for other health providers, but they usually only have an impact in one area, and they cannot be replicated in mainstream services, because of the cost. The Naguru Teenage Centre in Uganda (see box) is a good example of such a beacon service.

- **Services located at other kinds of centre**

Because some adolescents are reluctant to visit health facilities, services can also be taken to places where young people already go. In youth or community centres, a nurse or doctor may hold special clinics, and peer educators can put

## Adolescent friendly hospital services in Argentina

The Hospital de Niños Ricardo Gutiérrez in Buenos Aires, Argentina, opened an adolescent health service in 1993, providing a front line service for young people and a post qualification training placement for doctors.

Adolescents travel long distances and are prepared to wait at the drop-in service because privacy and confidentiality are assured.

Diana Pasqualini, Co-ordinator of Adolescent Clinical Services at the hospital, says: “We offer curative and preventative health, detect and treat problems and give information and advice.”

Hospital specialists provide clinical services and counselling as part of a knowledgeable multi-disciplinary team whose members are willing to listen and know how to reassure.

Young people often attend with symptoms of pain, but the most common diagnoses are

infections or emotional problems, with underlying factors, such as parents separating, family violence or poverty. Most do not have serious illnesses but some have serious problems, such as extreme unhappiness with their body, sexual activity without protection or problems with drink or drugs.

Younger adolescents have their growth and development monitored and receive information or counselling about body changes. Older adolescents ask for advice on a wide range of issues from sexual problems to employment.

The service recorded 13,543 consultations in a single year, of which 7,983 were for medical or development issues, 4,809 were psychosocial for eating disorders or family disruption, while 751 were for social problems, including young people at risk of violence or sexual abuse.

## Naguru Teenage Centre — ‘We dance to their tune’

The Naguru Teenage Information and Health Centre is attached to a health centre five miles from Kampala, Uganda, providing affordable, accessible and confidential services.

The service began as the initiative of a few professionals, but grew into a one-stop centre offering a wide range of services including antenatal, maternity services and services for sexually transmitted infections. It is funded by UNFPA and supported by the Ministry of Health. Dr Florence Abanyat, Assistant Commissioner of Reproductive Health Services, points out that a third of mothers who die in childbirth at health facilities in Kampala are adolescents.

Attendance by young people at the Naguru Centre doubled from 3,700 to more than 8,000 between 1996 and 1999. It provides services for young married couples, and negotiates with

schools to allow young unmarried pregnant girls to stay in class for as long as possible.

Young people train there as volunteer peer health educators, and they have been successful in reaching other young people, especially through an innovative radio programme.

Community educators host a phone-in programme on Radio Simba funded by UNICEF. The Speak Out Teen Show is aimed at out-of-school young people and at parents. More than half of the adolescents who use the centre heard about it from the show. Some go on air to talk about how they tackle their problems.

Edith Musika, Project Manager, said: “One thing that is very important to us is that young people accept the Naguru Centre as their own place. We take our time and we understand them and we dance to their tune.”

## Estonia Youth Centres provide free counselling

In Estonia, health providers based at youth centres, provide counselling and basic services for young people up to the age of 20.

Staff at 15 youth centres offer information and counselling about body changes, sexual relationships and advise young people how to prevent sexually transmitted infections (STIs) and unwanted pregnancies. They diagnose and treat STIs and test for pregnancy.

Services are free to young people, and are planned by municipalities and provided by not-for-profit organisations or private practitioners.

The Estonia Family Planning Association (EFPA) acts as an umbrella group that organises counselling services and ensures that they remain of high quality.

Adolescents are enthusiastic about the service, which they can even consult over the Internet or by e-mail. One young person commented: "Thank you for removing my fears." Others listed benefits as:

- no appointments and no need to queue,
- able to obtain prescriptions and pills,
- able to deal with all kinds of problems,
- young and competent doctors,
- trustworthy — treat you as an adult,
- private, comfortable and convenient,
- no tense atmosphere,
- open at convenient times,
- nice furnishings.

young people in touch with relevant health or social support services. One advantage is that such centres are already used by adolescents so that they do not have to make a special effort to go there. One drawback is that a particular centre may only attract part of the adolescent population, being used mainly by boys or by girls or by one age group. However, if a number of centres are used this can be overcome. Health services in Sweden reach large numbers of adolescents, including an increasing number of boys, through a network of youth centres nationwide. This service style has also been adopted in Estonia (see box on this page). All centres, whether provided in health facilities or in youth centres or elsewhere, should make good quality health information literature available and, where possible, show relevant videos to adolescents in waiting areas.

### ● Outreach services

In both urban and rural areas there is a need to provide services away from hospitals and health centres, to reach out to young people who are

## Friend Corners — Thailand

In Thailand, the Ministry of Public Health has developed 350 Health Promoting Hospitals, committed to health promotion and to making health services more user-friendly. In 2001, the Department of Health began to introduce *Friend Corners* outside school and college hours in local shopping malls and community housing areas. The first point of contact is with adolescents trained as peer counsellors. Health staff are also on hand to provide counselling or basic primary care or to refer adolescents to specialised services as necessary. The *Friend Corner* web site combines music, fashion and health information, and has been praised for making information accessible in an attractive way.



unlikely to attend. Increasingly in towns and cities services are being provided in shopping malls, as well as in community or youth centres.

Some countries have promoted services on the Internet to catch the attention of young people who have access to computers. Adolescents in remote rural areas are often excluded from routine health services. Health workers from local centres can take mobile services to visit villages to reach adolescents over a wide area. Services provided in village halls can include screening and immunisation with a discrete follow-up appointment service for those who need further treatment or counselling. Visiting health care providers can also provide health education talks and materials targetted on young people.

Outreach services are also needed for adolescents who slip through the net although they may be geographically close to an existing health facility. Young people living on the streets find it difficult to access mainstream services but will respond to services targetted on this vulnerable client group. Such outreach services

### Winning community support

A survey by Zimbabwe National Family Planning Council found that unmarried young people could not obtain contraception because elders and service providers disapproved.

Local authority social services committees funded multipurpose community service centres, open in the early evenings and on Saturdays, so clinic staff could provide counselling, contraceptives, pregnancy testing and information or refer young people for HIV tests or counselling about violence.

Village community workers, traditional midwives, youth leaders, teachers and nurse aides were trained to offer a confidential and non-judgmental youth-counselling service, at schools, community centres or health facilities.

The scheme gained parental and community support for services to adolescents. A final report called for its national expansion.

## Philippines - Linking street children to health centres

Childhope Asia-Philippines trains street educators in Metro Manila to improve access to services for other street children, including adolescents.

Childhope had been running its street educator programme successfully for a number of years. It extended the program to train junior health workers aged 11-15 to provide street children with health information and support and an opportunity to go for treatment. Junior health workers are themselves living on the streets and are selected because they are literate, have leadership skills and show sensitivity.

They learn about child rights and the problems that adolescents may face from substance abuse, sexually transmitted infections and HIV/AIDS. After four days training on common illnesses, health care and personal hygiene, junior health educators improve the health of other street children. They interview their peers,

using a prepared form to run through a checklist of common symptoms. The junior health worker can refer an adolescent to health centres which have agreed that a homeless young person who arrives with a completed checklist will be treated for free. In this way, junior health workers reach young adolescents who are vulnerable and hard to reach, and raise the awareness of health centre staff to the needs of street children.

Junior health workers promote personal hygiene, carry out basic first aid, and educate other street children about substance abuse, nutrition and wound cleaning.

They attend regular meetings to update their knowledge and improve their confidence. Some have been selected to train as 'walking paramedics' in accident and emergency centres, learning first aid and basic life support.

Doctors, nurses, and social workers formed a joint committee to support the scheme.

## How can this service be delivered?

may be run from health clinics or provided by NGOs. Once contact is made with young people who are outside the system it is important to find a way to create links between the outreach team and mainstream services.

- **Health services linked to schools**

Schools provide a natural entry point for reaching young people with health education and services. In the five years to 1996, it was estimated that the number of children enrolled in primary education increased by approximately 50 million, and the increase was most rapid amongst girls. Secondary school enrolment is also increasing.



*Students take part in a sex education lesson in the Seychelles.  
Photo: WHO, Geneva*

### School health clinics expand services in Tunisia

Tunisia has a 50-year tradition of school health services and a network of family planning clinics across the country.

Doctors and nurses at 2,000 health centres deliver services to young people in 9,000 schools and colleges. They monitor young people's health, provide immunisation, check height and weight, advise on nutrition and personal hygiene and carry out special puberty checks.

In 1990 the School and University Medicine Service was given lead responsibility for adolescent health. The service noticed that students often did not talk about problems until they were desperate. There was an increase in attempted suicide. Pregnant girls might conceal the fact until the fourth month of pregnancy. A warning signal of distress might simply be a student asking the doctor to excuse them from lessons or sports on medical grounds.

There was also pressure for change from young people. Family Planning services are adjusted to the needs of married people, yet people marry much later. A project to improve adolescent knowledge showed that they also needed skills and services.

The student health service began to change. Doctors and nurses set aside a day a week to see students. A reproductive health service was introduced, supported by midwives and gynaecologists from local hospitals.

In a collaboration between the National Office of Family Planning and Population, Student Health, Jeunes Medecins Sans Frontiere and the Tunisian Association of Family Planning, every major town now has at least one health or family planning centre offering a service for young and unmarried people.

The programme, that includes peer education and a specialist counselling referral service, has already contributed to a decrease in unwanted pregnancies and sexually transmitted diseases, and research is under way to discover the needs of adolescents at different ages.

Dr Alya Zarrouk, Director of Student Health in Tunisia, is optimistic. "We are offering a service that is changing in the way that adolescents want. Young people are already accustomed to going to these centres for their health needs, and it is easier to go there for reproductive health issues as well."



*Anastella Francis questions a student in Mwanza, Tanzania, to find out how the project has improved his knowledge.*

*Photo: David Ross*

## Peer educators and teachers win the trust of parents

In Tanzania the *MEMA Kwa Vijana* project trained peer class educators in 62 primary schools in rural Mwanza to bridge the gap between what was expected of young people and their daily reality.

In theory, young people abstain from sex until they are married. In fact, many become sexually active by the time they are 15 and many girls leave school early because they are pregnant.

The project trained three teachers in each school to teach about sexual and reproductive health, and about how students can keep themselves safe. Six students in each class have been trained as peer educators, able to advise fellow pupils and start discussions within more formal sessions.

Over a three year period, more than 1,800 peer educators have been trained and *MEMA kwa Vijana* clubs have opened at each school where the project operates.

Parents find it difficult to talk to their children frankly about sex and, at first, some were shocked, that their children were being 'taught how to have sex'. Over time, opinions changed. The project is welcome in the community, lessons are popular with the students and peer educators have respect and status in their classrooms. Parents are relieved that teachers are talking to young people about issues that they find difficult to raise themselves. An annual test carried out by the schools shows a significant increase in adolescent knowledge.

Schools are ideal places to screen for or treat a range of common illnesses, to provide vaccines such as booster tetanus shots, and for health and hygiene education.

However, in practice this potential is seldom realised. Schools are short of resources and teachers have neither the training nor the equipment to deliver health education on top of their existing workload. To turn this around

requires effective training to build the motivation and skills of staff, and may require outside support for sex education lessons. Some successful schemes train young people as peer educators in schools.

As with outreach work, it is important to link school health services to local health services, so that students who need follow up care receive it, and so that efforts are not duplicated.

It is also important to ensure that services provided at school have community support. Many headteachers are concerned that they will open themselves to criticism if they provide services for young people. Work needs to take place between the school and community to ensure that such moves are supported. There is much evidence that parents welcome other responsible adults talking to their children about sensitive issues, as they often feel unable to deal with these issues at home.

### ● Workplaces

Employers and trade unions both have an interest in services that help to keep the workforce healthy, and many workers in workshops and factories are adolescents. Peer education on HIV/AIDS has been carried out in workplaces in parts of Africa. In Sri Lanka, the Ministry of Labour provides outreach programmes in boarding houses and factory based education sessions to meet the reproductive health education needs of young women working in 200 factories in the country's Free Trade Zones.

The Ministry also conducts a general skills course for the large number of female workers who are migrating to the Middle East, many of whom are adolescents. An extra day has been added to this 12-day course for reproductive health education. ■

## Summary

- Adolescent friendly health services can be delivered in health centres, in the community, through outreach services or at school.
- Hospital or clinic based services can become more adolescent friendly.
- Community settings include services provided at community or youth centres, in shopping malls or even over the Internet.
- Outreach services are needed in cities to contact adolescents who do not attend clinics and those, like street children, who are marginalised.
- Outreach services in rural areas can be devised to reach young people living in isolated communities.
- Schools offer a critical entry point to bring services to young people who are in school.
- Young workers, including adolescents, can be reached with health education or screening services targeted on the workplace.
- Services can be located anywhere where young people go — no single setting should become the only model.

## Linking schools to health clinics in a rural area

In Malaysia, the Ministries of Health and Education have developed health promoting schools with policies covering the physical environment, the social environment and personal health skills. The schools mobilise communities to support young people's health.

School health services screen the nutritional status of young people, and alert authorities to cases of dengue. They offer immunisation, dental health checks and treatment. They address the mental health needs of adolescents and issues leading to violence.

The Ministry of Education, in partnership with a range of national bodies, introduced a sexuality module on family life education into schools. Staff or volunteers from the Family Planning Association of Malaysia (FPAM) deliver sexuality lessons, if teachers lack the skills or confidence to do so.

In Kota Tinggi District, a WHO supported project saw adolescent attendance rise by 62% at local health centres which improved adolescent services, quality of care, staff skills, the physical conditions of centres and referrals.

# Developing adolescent friendly health services



**T**his booklet argues for a new approach to adolescent friendly health services. But how do policy makers who are convinced of the need for action get started? A Resource Document, *Adolescent Friendly Health Services — Making it Happen*, is being published by the WHO Department of Child and Adolescent Health and Development in Geneva as a companion to this document. The Resource Document goes into detail to suggest ways to take this issue forward. The main tasks are outlined in this section.

## Adolescent status and health seeking behaviour

Research into adolescent health should seek to answer two questions: *What is the current health status of young people?* and *What do adolescents want from health services?*

Health surveillance, and research into the pattern of use of existing health services will provide information about the existing conditions affecting adolescents.

Surveys, focus groups and face to face interviews can provide an insight into behaviours that put adolescents at risk, and into

protective factors that help to keep them safe. Surveys can investigate the knowledge and beliefs of young people, investigate what they do when they are concerned about their health, and why they use, or do not use, existing services.

## What services are needed?

An overall strategy spelling out what health services are to be delivered to which groups of people needs to be developed. The strategy should cover health promotion, the prevention of health problems, curative services and rehabilitation.

## What services are available?

The team developing services needs to take a close look at what services are already in place and how successful they are in meeting the needs of adolescents. Do existing services cater for this age group, and if so what services do they provide? What is available in a city hospital, a health centre in a medium sized town, or at a rural health centre? How far are adolescent health needs met by generic services, and what special services are available?

Are there any outreach services for those in rural areas who live far from health facilities,

and for those who, for whatever reason, are unable to use existing services? Are these services consistently available? Are there adequate supplies of vaccines, medicines, condoms etc?

Do all adolescents have access to these services? Do services have barriers related to age, sex or marital status? What happens to adolescents who cannot pay? Are young people who are homeless, or refugees, or belonging to certain ethnic groups excluded? Are clinics open at convenient times, in the right places? Whose needs are not being met?

### *A strategy for planning services*

The strategy aims to devise or adjust health services to meet the needs and fulfil the rights of adolescents. It should identify where services will be based, which staff will deliver them, the quality standards they will work to and any training and staff support needed to achieve them. Steps towards planning and implementing a strategy include the following:

- **Achieve a national consensus for action**

A policy initiative to raise the profile of adolescent health services identifies departments and individuals to start the process of change, and sets up structures through which change is brought about. Political support is important to start the process and to ensure that all government departments collaborate, bearing in mind that health and development needs cannot be met by health services alone. Political backing is critical for winning community support and developing a national sense of urgency.

- **Decide on essential services to be provided**

Research referred to earlier in this section provides the basis for a situation analysis to identify public health priorities, adolescent health status, adolescent health needs, services adolescents say they want and any gaps in services. As explained on pages 19&20 the set of essential services for each country can conform to general principles but must be based on particular circumstances and priority issues.

### Political support

In **Ghana** the President's wife gave her personal support to programmes to sensitise the population to adolescent reproductive health.

In the **Philippines** the Department of Health liaised with the National Youth Commission, based in the office of the President, and with many other government departments to ensure that a National Adolescent Health Strategy launched in 2001 was widely supported.

In **Malaysia** the Deputy Prime Minister launched a programme for adolescent health and development in October 2001, after a three year development process involving the Ministry of Health with the Ministries of Youth and Sport, Education, Welfare, Religious Affairs and with many professional bodies.

- **Define the core values of the service**

An adolescent friendly health service has the characteristics outlined in the section *What makes Health services 'adolescent friendly'?*, (pages 25-29). The characteristics of adolescent friendly services are summarised on page 27 and more detail is given in the Resource Document *Adolescent Friendly Health Services — Making it Happen*. These are guidelines not blueprints and must be interpreted and introduced in a way that is appropriate to the cultural, social and economic context in which the services will be delivered. The fundamental principles, however, remain, so that services are accessible, acceptable, appropriate for adolescents, equitable, inclusive, effective and efficient.

- **Identify and set quality standards**

Based on national policies and research about the needs and opinions of young people, set quality standards for service providers, and develop and implement a quality improvement

process to achieve them. This document has already outlined key quality issues.

Are staff knowledgeable about the issues that adolescents raise? Do they have the technical skills to provide effective care? Do they have the right equipment and supplies?

What kind of a welcome do adolescents receive when they arrive? Do they have to wait a long time to be seen? Do they get privacy, before, during and after the consultation? Are their details kept confidential? Is there information and counselling as well as treatment? Are risk factors addressed in any way?

It is important to set specific standards for performance and to agree context specific criteria on which they will be assessed. For example, if the standard is that the provider maintains client privacy, the criteria could be:

- The door is closed during the examination.
- Other people queuing cannot overhear what is being said.
- Other people do not walk in and out during the examination.
- The adolescent is asked to give consent (and can refuse) if medical students are to observe.
- A patient who needs to undress can do so in private, and will be covered by a sheet so far as possible during the examination.

- **Put in place or strengthen a process for quality improvement**

Systems need to be put in place to identify gaps between existing and desired performance levels. They should include provision for regular quality checks through internal (peer-review) and external review, and also include interventions to address areas of weakness. Training programmes need to be revised to ensure that staff are knowledgeable, skilled and welcoming, and that training is repeated and skills are updated. Pre-service training should be amended to include adolescent health and development issues, as well as a communication skills component. Management and supervision should focus on supporting staff to achieve and maintain quality standards.

Training alone will not resolve quality issues. Structural problems must be addressed so that equipment, medicines and supplies are available when and where needed. It is important also to consider the working conditions of health care providers. A nurse in a busy understaffed clinic who is overworked and feeling undervalued is less able to focus time and quality care on patients. Ongoing research is needed to identify problems. Evaluation of services by adolescents is a key component of such research.

## Going for the Gold Standard in South Africa

In South Africa, The Department of Health and the NGO loveLife launched a National Adolescent Friendly Clinic Initiative to make health care services more accessible and acceptable to adolescents. Clinics can sign up for the 'Going for Gold' programme which sets criteria for the clinics to improve standards. To achieve accreditation clinics must:

- have management systems that support adolescent friendly health services;
- have policies and processes that support the rights of adolescents;
- make appropriate adolescent health services available and accessible;
- create a conducive physical environment;
- have the right drugs, supplies and equipment;
- provide information, education and communication;
- have systems to train staff;
- offer psychosocial and physical assessment and individual care based on standard guidelines and protocols;
- provide continuity of care.

### ● Link related services

Services from the Department of Health are only half the story. Other Government departments, notably Education and Social Welfare include health services in programmes. Many NGOs also have a health component. Links strengthen programmes, and avoid

duplication and confusion. Agencies should know what others can offer and how to access mainstream services. Developing consistency and co-ordination between services at specialist centres and in neighbourhood health centres is important, so that care is followed up and harm reduction messages are reinforced.



Peer education in India.  
Photo: WHO, Geneva

## Indian hospital minimises the cost of improved services

The Safdarjang Hospital in New Delhi, India, developed an Adolescent Healthcare Network (SHAHN) involving schools, colleges and NGOs. SHAHN provides adolescents with information, education and health services. It includes a specific package of care designed to address sexual, reproductive and nutritional health needs, emotional and mental health problems, and problems associated with substance abuse and violence.

The service began after a survey of 15-19 year-old students revealed physical and psychosocial needs. Doctors at Safdarjang Hospital, a large government hospital in New Delhi, could see that adolescents felt out of place in outpatient clinics. The hospital launched the SHAHN network with partner schools and colleges.

Dr R N Salhan, who was Medical Superintendent at the time, said: "We were convinced that we needed to develop specially designed service for the adolescents, as they constitute a

specific and a sizeable section of the society with a specific set of needs. Adolescents consider themselves healthy and do not give much attention to problems related to nutrition, maladjustment, sexuality, and even if they are concerned they do not know where to go, or hesitate to visit the existing facilities."

SHAHN has improved services for adolescents but required only a minimal additional budget, because:

- The hospital was already providing services for adolescents; no additional equipment or medicines were needed.
- SHAHN trained existing staff in counselling skills; there was no need for new personnel.
- NGOs offered voluntary services.
- There was no infrastructure cost.

Some funding from WHO was used to produce leaflets and forms, develop learning materials, train staff and pay travel costs to partner schools and colleges.

- **Involve young people and communities**

Involving adolescents in designing, delivering and monitoring services improves relevance, acceptability and effectiveness. This helps to:

- ensure that programmes are relevant to young people,
- identify messages, communication channels, resources and activities,
- encourages adolescents to communicate about programmes and commodities to their peers and others in their communities,
- develops a sense of ownership,
- develops skills, self-esteem and leadership.

Involving different youth — married, unmarried, out of school, in school, different ethnic groups etc. — helps to identify whose rights are not met and to address these gaps.

Involving communities is also important. Communities set the social limits on what

services can easily be provided. Involving parents and communities can dispel ignorance and build a culture of support for adolescent health services that ensures they will be used.

### How WHO can help

WHO, UNFPA and UNICEF have agreed a common approach to programming for adolescent health and development.

Through its Department of Child and Adolescent Health and Development in Geneva, WHO can provide technical information and tools to assist with country level programme design, implementation and evaluation.

Through its regional structure WHO can also support country level initiatives. Details of how to contact the Department of Child and Adolescent Health and Development can be found on the inside front cover of this publication. ■

## Costa Rica delivers rights to adolescents

The Costa Rica National Adolescent Health Programme (PAIA) was launched in 1989 to provide a quality service to young people based on a rights agenda. More recent legislation has guaranteed every adolescent access to free health care.

PAIA began with the aim of providing comprehensive clinic and hospital services to young people between the ages of 10 and 20. Today PAIA aims to develop the ability of primary health care teams to provide services for adolescents, and to develop adolescents themselves as health educators.

Each primary health care team monitors adolescent growth and development. In the year 2000, primary health care teams also began to screen for psychosocial risk factors. A questionnaire uncovered high levels of need for counselling, the major risk markers being depression and problems with alcohol. PAIA has started training 30,000 health workers in

counselling and adolescent issues.

Health centres host workshops to build self-esteem, and promote the rights of young people. Adolescents train as peer health promoters, and some represent young people's views on divisional and national groups.

The Department of Health takes the lead in implementing a law to support pregnant adolescents, offering a six-month skills programme before the baby is born.

The school health system has been strengthened. School nurses are trained to offer counselling. Sexuality education has been integrated into the school curriculum. A telephone hot line – *Cuenta Conmigo* (Count on Me) – is open to young people.

Dr Julieta Rodriguez, Director of the National Health Programme for Adolescents, says that there is a national consensus that adolescents are a priority. “We are very open with young people and encourage them to participate.”

## Rural services in Mexico

In Mexico, many of the 22 million adolescents live in remote rural areas, and a national network of health centres was reaching less than 10% of young people with services.

In 1997 the programme IMSS-Solidaridad introduced *CARA (Rural Health Centres for Adolescents)* to bridge this gap in rural areas. CARA establishes space for adolescents at primary level services and meets their needs for information, counselling, health education and self-care.

CARA is now reaching more than five million rural adolescents. In addition, health education material has been added to informal education programmes that target people in rural areas through TV and radio.

In each of the 32 states, religious groups, scouts, sports coaches and others with an interest in adolescent development are being brought into the programme.

## Summary

- The process of developing effective services begins by discovering the health status of adolescents, and what they do when they seek help.
- A strategy is needed to decide what services will be delivered, where and by whom.
- This will include an essential services package, core values, quality standards and a process for quality improvement.
- Links are needed with other services for young people.
- The participation of young people is needed to provide relevant, acceptable and effective services.
- Community support is needed to ensure that services are acceptable and used.
- WHO can provide advice and technical support.



Adolescent girls in Malaysia. Photo: Associated Press

# Challenges and benefits



**R**esponding to the health and development needs of adolescents requires a broad response that goes beyond what health services can do alone. The legal and social framework is determined by governments and by the society in which young people grow up. The main teachers and guides for young people are parents and families. Young people are also influenced by their teachers, religious leaders, friends, and, increasingly in an era of globalisation, by mass media. However, health services have a unique role, partly because health care providers possess special skills and knowledge, but also because services can intervene at critical points as young people develop and when they are going through a process of change and looking for answers.

Major challenges lie in creating the political and community support to make changes, and in managing and funding the process. Making major changes, such as recruiting new staff or constructing new premises, is a particular challenge if health budgets are not increasing. The aim must be to ensure that adolescent services receive a fair share of existing resources, and that the best use is made of them, to invest in the workforce and strengthen systems.

If the changes also engage the energies of adolescents themselves, this approach will make a real difference to young people. This will start the process that in time will lead to a reduction in the burden of mental health problems, accidents, violence, unwanted pregnancies, dangerous terminations, HIV and sexually transmitted infections in this age group. It will also lay the groundwork for reducing the major causes of early death in later life, heart disease and cancers.

It will also have an impact on future generations. Whatever this cohort of adolescents learns and whatever changes they make in their lives, they will pass on to their own children in time, as they become parents. The effects of a positive interaction with the current group of adolescents will in this way have benefits for generations to come.

Finally, improvements in adolescent health services will act as a catalyst to improve health services for everyone, as staff attitudes change and people's expectations rise. Adolescents are on the verge of adulthood, and will continue to demand services that match their needs. Adolescent friendly health services can pioneer change for the whole population. ■







# Adolescent Friendly Health Services

An  
agenda  
for  
change



For further information please contact  
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