Multistakeholder consultation to promote adolescent well-being in the WHO European Region

6–7 July 2021
Adolescents taking the lead

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Abstract
The European regional consultation meeting, part of the global initiative to strengthen prioritization of adolescent well-being led by WHO and the Partnership for Maternal, Newborn & Child Health (PMNCH), working with the United Nations H6+ Technical Working Group on Adolescent Health and Well-being, took place virtually on 6–7 July 2021. The core of the consultation event was groupwork. Participants reviewed key issues as they relate to adolescent health and well-being in the WHO European Region to identify policy implications for countries and highlight technical and other resources needed to support countries in accelerating progress towards more equitable health and well-being in adolescence. This report summarizes the event, focusing on suggestions arising from the groupwork that can be fed into the wider consultation process.

Keywords
ADOLESCENTS
WELLBEING
DIGITALIZATION
EDUCATION
MENTAL HEALTH
NUTRITION AND PHYSICAL ACTIVITY
RELATIONSHIPS AND CONNECTEDNESS
SEXUAL AND REPRODUCTIVE HEALTH
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The consultation event was hosted by the WHO Regional Office for Europe with the Partnership for Maternal, Newborn & Child Health (PMNCH), United Nations Population Fund (UNFPA), United Nations Educational, Scientific and Cultural Organization (UNESCO) and United Nations Children’s Emergency Fund (UNICEF).

This work is part of a global process led by WHO and the United Nations system of partners in health called the H6+,

1 specifically its Technical Working Group on Adolescent Health and Well-being, which aims to strengthen the prioritization of adolescent well-being in national policy-making.

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1 The H6+ partnership harnesses the collective strengths of the PMNCH, UNESCO, UNFPA, UNICEF, UN Women, WHO and the World Bank Group to advance the Every Woman Every Child Global Strategy and support country leadership and action for women’s, children’s and adolescents’ health and well-being.
FOREWORD BY THE DIRECTOR OF COUNTRY HEALTH POLICIES AND SYSTEMS

The European regional consultation summarized in this report, which is part of the global initiative to strengthen prioritization of adolescent well-being led by WHO and the Partnership for Maternal, Newborn & Child Health (PMNCH), working with the United Nations H6+ Technical Working Group on Adolescent Health and Well-being, brought together experts and adolescents from across the WHO European Region. The work carried out over the two days of the consultation will help us to review the problems currently experienced in child and adolescent well-being and help to define what needs to be done in this critical phase. As countries recover from the COVID-19 pandemic and seek to build back better, we need to make sure that the health and well-being of children and adolescents is a top priority.

The meeting had strong participation from young people from across the Region. This is vital, as their voices must inform and shape the work we are planning to do in Europe. The participation of young people in the consultation and in our ongoing plans is essential.

The whole focus on adolescent well-being starts from adopting a strength-based approach to increasing their confidence, competence and skills acquisition. It is about strengthening their sense of connectedness to their community, their parents or guardians, their peers and their places of learning.

Adolescents are not a homogenous group. The experience of adolescence varies dramatically in our Region and depends on many factors – social, educational, economic, political and health and well-being. Those living with the least advantages – children in poverty, refugees and asylum seekers, those with disabilities or chronic illness – risk facing exclusion and diminution of their life chances and health and well-being status. We must ensure that the actions we take in partnership with children and adolescents safeguard those who are most vulnerable and leave no one behind.

The time is right for us all to join hands – countries, governments, organizations and children and adolescents – and redouble our efforts to make sure that we can use the actions that arise from the consultation to build a stronger coalition around adolescents. Working with children and adolescents and our great partners in the PMNCH, the United Nations Population Fund, United Nations Educational, Scientific and Cultural Organization and United Nations Children’s Emergency Fund, we have a solid foundation from which to build new worlds that are shaped by children's and adolescents’ perceptions and needs, address the inequalities that hold back so many children in our Region, and promote and cherish the rights of children and adolescents.

Natasha Azzoardi Muscat
Director, Country Health Policies and Systems
WHO Regional Office for Europe
As young people from various parts of the WHO European Region, we may speak different languages, yet our ambitions and dreams are the same: we aspire to bring our creative and innovative contributions to this world! In fact, people say there are seven wonders of the world. We believe there are eight. The 8th is the health and well-being of children, adolescents and young people. Let’s take a look at the three columns of our “Palace of Health and Well-being” (see figure), which should stand strong and continue to prosper!

**First column: consultations and shared decision-making!** Bearing in mind the importance of young people’s involvement in democratic action and in consultations like the event to promote adolescent health and well-being in the WHO European Region that took place on 6–7 July 2021, adolescents should have a chance to be heard and to express their worries and wishes. This meeting is evidence of the success of youth participation in decision-making – the adolescents involved were dynamic participants, respectful of others, and committed to the event. Consultations like this provide a healthy and accessible way for adults and adolescents to exchange insights on the world of tomorrow. Future generations inherit the unfinished work of the previous one, meaning they will have to deal with a degrading environment, new health menaces and recovering economies. It’s our task to make sure they inherit a better world, hence the need for shared decision-making.
Second column: realization of leadership and creative potential of young people!
Recently, the world has relied on the potential of young people to solve global problems. We’re all for it! But we want to do this through the lens of creativity and leadership. By developing our creative potential, you will ensure we can interactively implement peace-building actions and promote healthy lifestyles through such global prisms as the Sustainable Development Goals and the European Code against Cancer. By enabling development of our leadership skills, you will support us to effectively motivate and inspire our peers to act together!

Third column: youth engagement! Being the 8th wonder of the world, health depends directly on working together. Given the positive experience from the adolescent consultation event, it is clear that youth engagement should become a fundamental part of decision-making. Adolescents’ voices provide an open-minded, fresh insight and can help to improve service access and provision, better work ethics and school curricula and a more equitable society. It is important to show teenagers that they are not alone and enable them not only to receive help, but also to provide it. For this reason, governments should invest in youth parliament activity and youth connectivity networks. They need to create and provide stable platforms to implement adolescents’ actions. That is an essential step to take towards a healthier, more equitable, sustainable and developed society.

Today, we children and young people may make up only 40% of the world’s population, but we surely make up all 100% of the future! Let’s be architects of our bright and healthy future together!

Daria Ambroci (Republic of Moldova), Shukurgeldi Myradov (Turkmenistan), Tomás Ferreira (Portugal)
MULTISTAKEHOLDER CONSULTATION TO PROMOTE ADOLESCENT HEALTH AND WELL-BEING IN THE WHO EUROPEAN REGION

BACKGROUND

The European regional consultation meeting, part of the global initiative to strengthen prioritization of adolescent well-being led by WHO and the Partnership for Maternal, Newborn & Child Health (PMNCH), working with the United Nations H6+ Technical Working Group on Adolescent Health and Well-being, took place virtually on 6–7 July 2021. The core of the consultation event was groupwork. Participants reviewed key issues as they relate to adolescent well-being in the WHO European Region to identify policy implications for countries and highlight technical and other resources needed to support countries in accelerating progress towards more equitable health and well-being in adolescence.

Conscious of the need to adopt a pragmatic approach, the partner agencies involved in developing the European regional consultation chose to concentrate on six areas for the groupwork:

- digitalization
- education
- mental health
- nutrition and physical activity
- relationship and connectedness
- sexual and reproductive health.

Many issues are relevant to adolescent well-being, as described in the Framework for Adolescent Well-being. Key issues were described in a series of global background papers that served also as materials for this consultation and were shared with the participants. In previous work, the European Region has identified problematic areas to adolescent health and well-being. A pragmatic matching process between the regional and global problematic areas as described in the background papers was used to prioritise themes with higher relevance to the European Region.

The regional consultation organizers shared fifteen global background papers and prepared background papers on the six topics to group members prior to the event (see Annex 1 for summaries). Youth participation, which was a keystone for the event and the consultation, had been promoted from early in the consultation process through partnerships with youth networks and groups. A pre-meeting with adolescents was held one week before the consultation to introduce the organizers, event details and the topics and open room for exchange between organizers and young people. More than 20 adolescents, aged 16-19, participated in the event, making highly valued contributions to the suggestions that arose from the groupwork.

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3 WHO HQ 15 papers on adolescent well-being [https://www.adolescents2030.org/adolescent-well-being](https://www.adolescents2030.org/adolescent-well-being)
5 These papers will be available soon on the WHO Regional Office for Europe website.
The suggestions from the consultation event and from similar events across all WHO regions will be taken forward at a global summit on adolescent health and well-being in a digital age planned for autumn 2023. They will also contribute at global level to the revision of WHO’s Global Accelerated Action for the Health of Adolescents (AA-HA!) guidance.

The agenda for the meeting is shown in Annex 2 and participants in Annex 3.

OPENING

Natasha Azzopardi Muscat (WHO Regional Office for Europe) opened the event by acknowledging that not all adolescents have been affected equally in the COVID-19 pandemic. Adolescents with strong family support and social networks and living in more advantageous socioeconomic circumstances have been better able to cope with the pandemic and the restrictions imposed to mitigate its effects. The suggestions arising from the groupwork should focus particularly on the needs of those who are most likely to fall through the cracks and to be left behind.

Valentina Baltag (WHO headquarters) explained that the aim of the proposed high-level global summit is to ensure that every adolescent can make informed choices about their lives and fulfill their potential to attain full health and well-being. The call to action for adolescent health and well-being invites governments, donors and the international community to:

- engage and empower adolescents in all legal, policy and programme processes that affect them;
- go beyond the health sector to launch a powerful multisectoral response in their countries; and
- strengthen political commitment and funding at the global summit in 2023.

WHO and the PMNCH have developed an adolescent well-being conceptual framework that aims to ensure all adolescents have the support, confidence and resources to thrive in contexts of secure and healthy relationships, realizing their full potential and rights. The framework defines five interlinked domains (good health and optimum nutrition; connectedness, positive values and contribution to society; safety and supportive environments; learning competence, education, skills and employability; and agency and resilience) with 27 subdomains. It has been embraced by the heads of United Nations agencies and has secured political support.

Eight regional consultations, of which this European consultation is one, are taking place to discuss the global framework and explain why national and local governments, nongovernmental organizations and others should invest in adolescent health and well-being across all five domains. The consultations are also seeking to identify the evidence-based policies and programmes needed not only to promote adolescent health and well-being globally and identify gaps to be addressed, but also to do so in the specific contexts of each region.

The PMNCH had prepared background papers across 15 areas, ranging from good health and

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6 Participants can sign up to the call to action at: www.adolescents2030.org
optimum nutrition in adolescence to the economic case for investment in adolescent health and well-being. Key messages from these are:

- programmes must embrace the multidimensional nature of well-being;
- both human rights and economics matter – not one or the other, but both;
- the heterogeneity of adolescence, including by age, gender, disability status, location, marital status and wealth, needs to be acknowledged;
- institutional mechanisms are needed to empower adolescents to engage with programme design, implementation, governance, and monitoring and evaluation; and
- digital technologies provide opportunities and challenges for adolescent well-being, with a danger of exacerbating inequalities for disadvantaged adolescents.

“Nothing about us without us – that message from adolescents is constant.”

Martin Weber (WHO Regional Office for Europe), Bobby Soobrayan (UNICEF) and Tigran Yepoyan (UNESCO) provided an update on adolescent mental health and well-being in the WHO European Region in relation to the themes identified for the groupwork.

COVID-19 has affected adolescent well-being in a major way, especially by its control measures. Almost all countries closed their schools, disrupting social contact. Combined with increased poverty due to economic uncertainties, exposure to domestic violence, and negative effects on nutrition and physical activity, impacts on mental and physical health and well-being were inevitable. Some of these impacts are likely to be long-term.

The following problems are prominent among challenges adolescents in the European Region face:

- adolescents cannot always access health services by themselves – in many countries, parental/guardian consent is required;
- adolescents face barriers in accessing sexual and reproductive health services;
- too many children and adolescents in the European Region are overweight or obese and are not sufficiently physically active;
- adolescents in Europe exceed the recommended daily screen time; and
- mental health problems are a major cause of mortality among adolescents.

Mental health is clearly a significant issue for adolescents. Suicide is the tip of the iceberg of mental health problems, but it is the leading cause of death in the Region among 10–19-year-olds in low- and middle-income countries, and the second leading cause in high-income countries.

The Health Behaviours in School-aged Children survey (HBSC) provides reliable data across a range of health behaviours among adolescents aged 11, 13 and 15 years. Data from the last round of the survey in 2017/2018 show one in four adolescents feels nervous, irritable or has difficulty sleeping on a weekly basis. Prevalence of multiple health complaints, like headache, dizziness and stomach ache, have grown slightly since the previous HBSC survey, although the increase among girls aged 11–15 is greater.

The Regional Office surveys Member States every few years on progress with child and
adolescent health strategies. One survey question asks about provision of community mental health services for early intervention and follow-up of children and adolescents with a first episode of severe mental health illness. Around 73% of countries report having such services, meaning 27% do not. This requires action, as children and adolescents need not be hospitalized to receive the mental health care they require.

Data from HBSC on *overweight and obesity* in 11, 13 and 15-year-olds show that it has increased in a third of countries since 2014 and now affects one in five adolescents. Influencing factors include social inequalities, with adolescents from poorer families being more likely to be overweight, obese and *physically inactive*.

Adolescents in some countries in northern and western Europe can consent to medical procedures based on maturity, as assessed by providers. In other countries, however, those under 18 require parental/guardian consent. This imposes a barrier to access to *sexual and reproductive health services*, including contraceptives. HBSC data show that a quarter of sexually active 15-year-olds did not use contraception at last intercourse.

All countries have made progress in formal *education*, but 3.4 million primary and secondary school-aged children were out of school even before the COVID-19 pandemic. In upper secondary, 1.8 million young people were out of school.

Many adolescents in school are not learning at the expected level. This will have serious impacts on their foundational and transferable skills, life outcomes and employment opportunities.

Digital technology provides great opportunities for learning, particularly when schools are closed, but inequalities in access to digital technology impose even further disadvantage on vulnerable groups of children who already are at risk of being left behind. Marginalized children, including children with disabilities, girls, children from the poorest families, ethnic and linguistic minorities and refugee children, are the worst affected.

The impact of the COVID-19 pandemic on learning will stretch years into the future; for very vulnerable and excluded children, it will last throughout their lifetime. Interventions therefore need not only to address the immediate problems, but also seek to put in place measures that will mitigate the long-term effects of the pandemic. Other services that use schools as a platform, like nutrition and health services, have broken down due to school closures and now need to be rebuilt and strengthened.

Attachments developed in the early years and *connectedness and positive relationships* with parents and peers contribute to promoting adolescents’ emotional and social well-being throughout the life-course. Only two thirds of adolescents in Europe and central Asia, however, report high levels of family support and easy communication with parents. Social and emotional well-being decreases as adolescents get older, especially among girls. Adolescents from poorer backgrounds experience less social support from family, friends and classmates.

When young people feel connected with parents, peers, schools and communities, feel safe, respected and accepted, have opportunities to develop their skills and networks and feel empowered to contribute to their families and communities, they are much more likely to achieve life goals and enjoy better health and well-being. COVID-19 lockdowns negatively impinged on all these elements of well-being, creating pressures on adolescent
connectedness, relationships and communication. The pandemic has also created other negative situations, such as parental unemployment, poverty, domestic violence and substance misuse, that impact on adolescent well-being. School satisfaction and support from teachers and classmates declines as adolescents get older, especially when they face bullying and violence in and around schools.

The last HBSC survey showed that about a third of adolescents use electronic media to communicate with others almost all the time during the day. Digital media can increase the coverage and quality of care for adolescents and provide information to manage health in general, but also can exacerbate inequalities for disadvantaged adolescents. Digital literacy is needed to equip young people to safely navigate digital spaces. HBSC data show that life satisfaction for adolescents is higher in countries where children do not have problematic social media use.
GROUPWORK

PROCESS

Each group discussed three questions related to one of the six themes identified during the consultation process. Following the groupwork, a rapporteur from each group reported findings and suggestions to the main plenary. It is these reports that are summarized here.

While each of the groups identified elements specific to the topic they discussed, cross-cutting issues that appear relevant across all areas of activity in relation to adolescent health and well-being were also identified. These are described in the “Cross-cutting issues” section that follows the summaries of the groupwork outcomes.

DIGITALIZATION

What should be done by national and local governments to make digitalization accessible for adolescents?

The COVID-19 pandemic has shown how rapidly things can move in the digital arena. Almost overnight, vast swathes of human communication in education, health and commerce moved to digital platforms as lockdown measures were introduced. In some ways, digital-aware young people were in a better position to cope with that than many adults, but this did not apply to all young people. The ill effects of lack of socialization negated many of the advantages of digitalization for them, particularly in relation to education.

It is very important that governments and the private sector set structures for digitalization through policies and governance. A vision for digital transformation of societies, especially as it relates to adolescents, and safety regulations for the digital world are needed. The vision should be of a digital world that is focused on responsible use, does not present opposition to adolescents being involved in physical activity and includes all generations.

Citizens of the 21st century need to have digital literacy. This means children and adolescents should learn digital literacy in schools as part of the curriculum. Schools therefore need adequate technology to support learning and teachers need appropriate competencies to teach.

Measures need to be taken to narrow digital inequalities. Closing the digital divide will ensure that all adolescents can be involved in the digital world. In the meantime, action should be taken to ensure that those without access to technology are reached through other channels. Free or cheap access to technology and the Internet should be considered a human right.

How can adolescents acquire skills to safely navigate in the digital world?

Education on ensuring safe navigation of online environments is central to this. Education on issues such as being able to distinguish between fake and real news and identifying and interrogating online marketing content should be provided in schools. Teaching should also focus on helping young people to understand the dangers and opportunities of the Internet. Parents should be supported to help their children in this area.
Regulations are needed to make digital navigation safer, but beyond this it is about enabling a digital culture that supports values of safe use, justice, equality and respect for all. The aim should be that everyone can participate in, and benefit from, the digital culture.

**How can adolescents themselves be involved in creating solutions/decision-making?**
The digital world is part of young people's worlds. Adults need to understand this and support young people to see the digital world as a supportive and safe space, while being watchful for signs of problematic use among young people.

Contextualisation needs to be considered in relation to young people's involvement. Young people live in different country cultures. This is not a case of defining a one-size-fits-all approach to digital involvement; approaches individualized to country, cultural and historical contexts will be required. It nevertheless is vital that adolescents have a voice and that people listen to their opinions, interests, wishes and concerns. They need practical opportunities to engage in all kinds of processes related to digitization. This could include providing incentives to adolescents to participate and create solutions to digital problems.

“We have to acknowledge that there is a digital world of adolescents. We all participate in the digital world, but it's different for adolescents, and we need to understand that, to grasp that, and to make use of that.”

**EDUCATION**

**Why is it important for stakeholders, national and local government, nongovernmental organizations (NGOs) and other stakeholders to invest in adolescents’ well-being through education?**

Education must be seen as a protective factor. Schools provide a setting where more than 95% of children and adolescents in the European Region can be reached.

**What innovative policies and approaches can be promoted by these stakeholders to improve adolescents’ well-being through education?**

School health services should be an integral part of school health promotion, with close collaboration established between schools and school health services.

There is a need to focus more on vulnerable young people. Out-of-school support should be recognized as being just as important as in-school support.

Health-promoting policies should encourage schools to implement the whole-school approach, focus on health literacy, empowerment and action competence, take into account the fact that schools are not isolated settings but are part of wider communities, and focus on school staff health.

Students' active participation in decision-making must be promoted, including when it comes to deciding on subjects to be taught in school.
What can and should be done as a priority to ensure that children and adolescents receive relevant subject knowledge and develop skills for a healthy life and future employment through formal and non-formal education?

The priorities are to make the best use of digital and remote learning while sustaining face-to-face classroom-based learning, and to rethink the content of education. Curricula should not just be about the acquisition of academic knowledge, but should also focus on social and emotional learning elements that support positive climates in classrooms in adolescents' lives.

The whole-school approach to health should be part of school policies, the school curriculum and learning activities, with health education being mandatory in schools. There needs to be a curricular approach, with critical and analytical thinking, to social and emotional learning. Interactive approaches should be adopted to the study of health-related subjects.

Peer-to-peer methods should be recognized as a way of learning and be applied in formal and non-formal environments. School staff need appropriate education and training, and close collaboration with parents, with a focus on supporting and empowering them, is essential.

What can and should be done as a priority to ensure that schools are safe, secure and enabling environments for study and socialization for all learners?

Close collaborations with surrounding communities and relevant partners can protect and safeguard young people, while also enabling students to have a voice. A specific focus on equity and inclusion could be applied to learning approaches that include innovative and cooperative learning strategies to make sure that all students experience an enabling social environment.

Civic education at a young age that allows development of social ethics and standards of interaction and respect should be prioritized.

An evaluation system is needed, but it is recognized that this may discourage some students and raise tensions in relations among schoolmates.

MENTAL HEALTH

How important is mental health for overall adolescent well-being, and why should governments and NGOs, invest in it?

There is a really important connection between mental ill health and positive functioning and well-being. Adolescence is a critical period in the development of human beings. What happens during those years will have a long-term impact on the future of individuals and societies. Mental health problems throughout the life-course have economic impacts. There is also a need to act now to address the short- and long-term mental health impacts on adolescents of the COVID-19 pandemic.

What evidence-based policies and programmes, national and local, are needed to promote adolescent mental health in different contexts?

Effective and evidence-based universal and targeted interventions are needed to address the specific needs of certain groups. These programmes should account for group differences, meet the needs of individuals and target groups, reflect people's readiness to participate and be open to change. Barriers to implementing such programmes include
the lack of a qualified workforce, lack of national, regional and local data to identify what
the main issues are and, even where data exist, limited data analysis skills. Stigma and
stereotypes around accessing mental health services also present a potential barrier.
National guidance is needed to ensure equitable access to mental health care for everyone.

How can adolescents themselves be involved in creating solutions in decision-making?
There is a need to create a space for younger people to be involved and have a voice
in policy planning. They should also have a vehicle through which they can share good
practices in youth engagement across the European Region.

Relationships between young people, researchers and policy specialists should be stable and
trusting, and adolescents should be provided with training and support in how to engage in
programmes.

It is very important to let young people ask questions and not always have professionals
asking the questions. This will enable young people to explain what is important to them and
ensure they are heard and that their voices matter.

NUTRITION AND PHYSICAL ACTIVITY

What are the barriers and facilitators that national and local governments, NGOs and
others face when investing in nutrition and physical activity programmes and policies?
Industry lobbying and pressure presents a key barrier. Especially in the time of COVID-19,
political priority-setting in terms of investing in nutrition and physical activity may not be
very strong. Systems-wide approaches to training, sustainability, nutrition, health and, very
importantly, equity are lacking in countries, and this is complicated by lack of sustainable
financing for programmes and policies that offer protection from industry influence. As a
result, many initiatives are taken forward through voluntary activity, which by nature may
be friable and inconsistent; this also presents a barrier to effective action.

What evidence-based policies and programmes, national and local, are needed to promote
adolescent nutrition and physical activity in different contexts?
Comprehensive action through multisectoral and upstream measures are required. These
can be supported through fiscal interventions such as taxing sugar-sweetened beverages
and applying marketing restrictions that encompass not just children, but also adolescents.
Physical activity can be facilitated through investment in infrastructure and positive urban
planning to promote activity.

Monitoring, evaluating and implementing are key. The focus often seems to be placed
on just one of these levels, but all three are important in ensuring effective policies and
interventions.

How can adolescents themselves be involved in creating solutions/decision-making?
The key facilitator for action has to be youth involvement and engagement. Currently,
engagement is often limited; if young people are engaged at all, it may not extend
throughout the whole process of design, implementation and evaluation. Involvement and
engagement of young people allows them to set out their own priorities for action and can
be taken forward through existing networks and projects, including schools and school
networks but also going beyond them. Countries with such facilities in place can act as good
practice examples for those that do not. Country examples and case studies are helpful
in supporting governments to implement policies, ideally with support from international organizations.

**RELATIONSHIPS AND CONNECTEDNESS**

Connectedness, positive relationships, values, and contribution to society are among the key factors that contribute to emotional and social well-being of adolescents. Factors that encourage connectedness and positive relationships include: positive parenting and supervision; safe and enabling learning environments; positive values and norms in families, schools, communities and societies; and opportunities to be socially, culturally and civically active.

What evidence-based or innovative policies and programmes can be promoted to support families and parents to better communicate with their children, facilitating their healthy development and well-being?

Some common themes emerge, covering the need for parenting support classes and services and the challenge of where to deliver them, and the nature of the content of these sessions. First and foremost, however, parents need to be engaged. Many ways of finding and engaging parents have been identified, including through schools, clubs, meetings, workshops and digital platforms.

Parent support should focus very strongly on communication skills, helping parents to understand the particular life-stage of their children, the need for respect of children and adolescents to encourage them to communicate with confidence, and how to achieve the tricky balance between providing protection and enabling freedom that faces all parents of adolescents. Crucially, work needs to promote an understanding among parents of how important they are and how influential they will be on their children's health and well-being now and in the future. The issue of so-called toxic parents – those who do not accept their children or who expect respect from them without giving respect to them – is acknowledged as a significant challenge.

Tried and tested resources exist to support parents, including "Programme 15", developed and implemented in many regions of the Russian Federation to bring parents and children (adolescents) together to improve communication and reduce risky and harmful behaviours such as substance misuse. Their use should be encouraged, particularly for parents whose children have special needs.

What evidence-based or innovative policies and programmes can be promoted to ensure that schools are safe and inclusive places to learn, socialize, obtain skills for positive relationships and provide empowerment for aspirations and responsible choices?

Listening to young people in the school context and having them involved through power-sharing arrangements in schools are examples of positive programmes that will bring benefits. This can be taken forward through, for example, school councils. More generally, health-promoting school or healthy school programmes and whole-school approaches to improving relationships within the school and promoting well-being as an appropriate outcome of education have a strong evidence base. Social and emotional learning can be integrated within curricula both as a specific topic and as a theme permeating other topics.

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* "Programme 15" can be accessed at: [https://human.org.ru/resource-center/program-15/]
If young people are asked about relationships at school, bullying is the thing that comes at the top of their list. Evaluated and effective programmes to tackle bullying inside and outside school already exist, including peer-to-peer mediation programmes.

The importance of looking after teachers – investing in their support, providing them with mental health support, preventing burnout, keeping their workload manageable and reducing stress – needs constantly to be emphasized. If teachers are stressed, they will transmit it to children and young people.

“We cannot solve communication and relationships within schools without looking after the staff who look after the children.”

What evidence-based policies and programmes can be promoted to provide young people with opportunities for meaningful contributions to neighbourhood, community and society? Involving children and young people and getting their perspective on what needs to be done, how it should be done and how it should be communicated is top of the list. Whatever policies or interventions are implemented need to work for young people first and foremost.

It is more difficult to intervene at community level, where mechanisms for delivery are fewer than within schools. A range of evidence-based programmes nevertheless exist, including opportunities for meaningful volunteering, skills-building and creativity, youth movements like the Scouts, and involvement programmes in areas such as environmental projects. Initiatives like these are critically important for the development of young people’s life skills, but they were hugely impacted by the lockdowns during the pandemic. Young people have spoken about how severe a blow this was for them.

A focus on diversity is important in this area, which raises many questions about gender and income equality, rights-based approaches and engaging vulnerable parents and young people who are harder to reach or more marginalized.

Above community level, a policy and legal framework that enables a focus on relationships is important.

**SEXUAL AND REPRODUCTIVE HEALTH**

Why should national and local governments, NGOs and others invest in adolescent sexual and reproductive health?

Stigma around sexual and reproductive health and sexually transmitted infection presents a big barrier. These topics should be normalized to allow appropriate planning and provision of services and adequate sexuality education for young people to be in place. Education should also have a focus on issues such as consent and sexual abuse. It was very difficult during the COVID-19 school closures to provide this kind of education, which is suitable not only for adolescents and young people, but also for children – it is about much more than sex, and also features issues like family relationships and gender equality in which even young children need education.
Governments should be pressed to form groups of adolescents and young people who can work directly with them to tackle the issues around sexual and reproductive health, including reducing stigma, enhancing access to education and services, and protecting confidentiality. At the moment, responsibility for different aspects of sexual and reproductive health tend to be scattered across different ministries or departments; a more joined-up approach is required.

**What evidence-based policies and programmes, national and local, are needed to promote sexual and reproductive health in different contexts?**

Governments should cooperate with adolescents, schools and parents to find out what works, drawing links between mental health, sexual and reproductive health, equality and education policies and curricula. Current evidence-based resources to enable young people to develop their understanding of sexual and reproductive health, some of which have been developed with input from young people, are known to be effective.

Where it does not already exist, national legislation should be enacted to ensure that young people across the Region can access confidential, adolescent-friendly, age-appropriate and free sexual and reproductive health services. They are also entitled to receive high-quality sexuality education in schools and from other evidence-based sources.

More research is needed to provide fresh evidence on the key sexual and reproductive health issues for young people. These data should be used to develop and implement national sexual and reproductive health programmes for young people that involve a coalition with all key stakeholders, who then will be able to implement and advocate for the programmes. The needs of vulnerable groups of young people should be prioritized through effective strategies.

Children need to learn about a wide range of issues, including how to identify the truth and trustworthiness of information they access on the Internet and how to pick up signs that a particular relationship might be dangerous for them. It is important, however, that sexuality education does not focus entirely on the negatives, but also highlights the positives. Because of this, those teaching sexuality education should be working in the area of sexual and reproductive health, so health workers may be in a better position to do so than teachers. Education should be evidence-based and should meet international standards.

Parents also need education in this area, as speaking about sex with their children is taboo for many.

**How can adolescents themselves be involved in creating solutions and decision-making?**

This comes back to the earlier point about the importance of governments forming groups of adolescents and young people who can work directly with them to tackle the issues around sexual and reproductive health. No one knows what interests young people more than young people themselves, so they need to be involved in creating media and other information activities targeted at them. For example, instead of using TV advertising to spread information, young people would probably prefer the use of platforms like Instagram and TikTok, with ads on Spotify and Apple Music instead of radio.
CROSSCUTTING ISSUES

There is much interconnectedness in the suggestions across all six areas, indicating the need for integrated approaches to address the identified problems. Some of these crosscutting issues are considered here.

Participation and engagement of young people

Participation and engagement of young people was the predominant cross-cutting issue, being cited as central to all the areas discussed. A co-creation approach is needed to ensure the involvement of young people in all the important processes related to their lives and guarantee their inclusion in decision- and policy-making processes.

Youth engagement is a long process and not a one-off activity, so it will take commitment, time and planning to implement effectively. It should be built on trust, with adolescents provided with training and support in how to engage in programmes (whether it be policy, research, school, health or other kinds of programmes) and given the opportunity to ask questions. It is crucial that youth engagement becomes integral to the design, implementation and evaluation of activities that affect them in all spheres and is not just considered a bolt-on part of specific projects.

“\textit{Involvement is not something we do to them, it's something that we do with them.}”

“\textit{We have to go where adolescents are, not try to pull them to where we are.}”

Policies and initiatives have to address what young people and adolescents are interested in and provide answers to their questions. Education curricula, services and research programmes should not be created from the perspective of what adults think young people need or what might be good for them. Too often, however, young people are missing from the discussions. Youth councils and other youth-organized groups, including youth parliaments, can influence adult decision-making, but may be used in a tokenistic way. Groups such as these provide platforms for young people’s voices to be heard, accepted and acted upon and should be seen in this light.

Involvement needs to go further. Young people need the power to lead, and they are taking it. Adolescents are taking the lead – the climate issue is a strong example of how adolescents are taking issues into their own hands.

Addressing inequalities and promoting rights

Participants across all groups were quick to emphasize how the COVID-19 pandemic has increased existing inequalities and that actions need to be directed to ensuring the most vulnerable and disadvantaged are not left behind. A focus on diversity is central in this regard to ensure that issues such as gender equality, income equality, rights-based approaches and engaging parents and young people who are harder to reach, more marginalized or vulnerable due to, for instance, disability or illness, are priority considerations when considering actions.
Inequities are found across a range of areas. They exist in relation to, for instance, language, minority status, urban or rural location, and access to technology, schools and information. All those context-related topics really matter and need to be addressed.

A central focus for participants’ discussion on equality and rights was the situation in which adolescents (those under 18 years) are deprived of their right to access health services without parental consent. This is detrimental to their health and could lead to more unwanted pregnancies, more unsafe illegal abortions, more untreated sexually transmitted infections and more cases of HIV. A similar problem exists for children in contexts where LGBTI+ communities are suppressed, and where talking about sexual diversity and gender identity in schools is prohibited. These children and adolescents are marginalized, feel isolated, and can experience depression and other mental health and communication problems.

One of the key messages from the PMNCH background papers is that “both human rights and economics matter”. Child rights are the essence of their ability to be involved and make choices. Issues such as access to essential health care and education about sexuality are at the core of adolescents’ rights to choose. The groups agreed that the United Nations Convention on the Rights of the Child should underpin all approaches to understanding and respecting children’s and young people’s rights.

It is important that international organizations, including WHO, also adopt a rights-based approach to engaging with children and adolescents. Organizations like WHO can provide a very helpful portal for promoting rights and sharing good practice and evidence among countries.

**Evidence, good practice and monitoring**

Ensuring actions are evidence based and subject to ongoing monitoring and evaluation was considered key by all the groups. Examples of useful evidence to support governments when they are devising and implementing policies range from country examples and case studies to large-scale international research studies, like HBSC. Policies that are not based on evidence may do more harm than good.
ANNEX 1: BACKGROUND PAPERS

DIGITALIZATION

This session will examine the opportunities and risks to which children and adolescents are exposed in online and digital environments and explore measures to help protect them from potentially harmful health effects and enable safety and confidence in their use. It will offer perspectives, including those of young people from the WHO European Region, on how governments can tackle the digital divide and ensure that adolescents and their guardians can develop the right skills to allow them to better navigate and manage risks within digital environments.

DIGITAL NATIVES

Adolescents today are growing up in an increasingly digital world. They spend more time online than earlier generations, at younger ages, and with more devices. Thirty-five per cent of adolescents use electronic media to communicate with others almost all the time throughout the day (intensive use). Boys are more likely than girls to report a preference for online communication.

Digital technologies have become an integral part of their lives, from play, to learning in school, to communication with friends and family. As digital natives, young people utilize a variety of digital tools, including websites, social media platforms, mobile phone applications and wearable devices, to find and access information, monitor their health and activity levels, establish communities of support and create content.

OPPORTUNITIES

Digital tools and the data they generate offer huge potential for increasing the coverage and quality of care for adolescents and providing them with information to manage their own health.

Most of these innovations, however, do not specifically consider the unique needs of children and adolescents as part of their design and implementation. This can lead to exposure to harmful behaviours and/or false and misleading information and result in missed opportunities for improving their health and well-being. Children also strengthen existing relationships, form new friendships and receive social support online.

INEQUALITY

Adolescents’ experiences of the digital world differ according to a range of intersecting factors, including gender, sexual orientation, disability, education level, physical location and socioeconomic status. Vulnerable population groups are often the least likely or least able to access health services via digital solutions due to limited access to infrastructure and the high cost of connectivity and devices. The COVID-19 pandemic has shown that not all adolescents benefit from digital technologies equally.

RISKS

The breadth of the digital environment can make young people vulnerable to certain risks, exposing them to harmful content, misinformation and potential abuse. Adolescents are especially susceptible to being misled by social media influencers or through approaches such as microtargeting, as they may not recognize the implicit commercial nature of certain content.
The compelling design of online games and social media platforms attracts children to spend hours in front of their screens. One in 10 adolescents reports intensive online communication with people they got to know through the Internet and did not know before. Children and adolescents are particularly susceptible to online marketing of foods high in sugar, salt and fat.

The International Classification of Diseases (ICD-11) has recognized addiction to gaming as a medical illness, and it has been suggested that excessive Internet use may encourage addictive behaviour. The association between the intensity of social media use and well-being seems complex and is contingent on several factors. Research shows consistently that problematic social media use threatens adolescents’ well-being. Seven per cent of adolescents report problematic social media use. Studies have found that excessive time spent online can also be damaging to the mental health and well-being of children.

PATH FORWARD
Without coordinated efforts, digital technologies may continue to accelerate existing inequalities in health outcomes, causing some children to be left behind. This could be a priority area for the European Region. The importance of strong governance and regulation of digital and online environments and data protection becomes even more pertinent to adequately protect children and adolescents. Digital literacy would help equip young people to navigate these digital environments safely. National, regional and global policies that safeguard children’s rights are needed to ensure that children and adolescents are adequately protected in digital environments and that their rights are not undermined in serving commercial interests.

As more children and adolescents come online and the influence of the digital world becomes even more pervasive, it is important to enable their capacity to mitigate risks while encouraging them to benefit from the opportunities provided through use of digital environments.

EDUCATION

A good-quality education is the foundation of health and well-being. For people to lead healthy and productive lives, they need knowledge, skills and agency to make healthier choices and prevent sickness. Education is associated with greater cognitive capacity, greater individual agency, longer and productive adult lives and more gainful and meaningful employment.

Receiving quality education and possessing relevant skills are essential assets for adolescents’ current and future well-being.

EDUCATIONAL DISRUPTION AND LEARNING LOSSES
Education is one of the greatest common goods, the value of which has become more obvious during the educational disruption caused by the COVID-19 pandemic. School closures have affected learners’ educational attainments, socioemotional development and well-being, as well as their social life, relationships, future life trajectories and employment.

Towards the end of 2020/2021 academic year, full and partial school closure affected 26 million primary and secondary school students (20% of the total number of students) in Europe and central Asia. These students were not attending school at all on average from 4–12 weeks. The longer students miss school, the higher is the likelihood of dropping out.
ACCESS TO EDUCATION
Over 4.2 million children of primary to upper-secondary age are out of school. Those with disabilities, from ethnic minority groups, refugees and migrants are far more likely than others to be out of the classroom. In some contexts, early marriages and early unintended pregnancies put an end to schooling for girls. Discrimination, violence and bullying faced by adolescents with non-traditional sexual orientation, gender identity and gender expression is yet another barrier to school access.

SAFETY AT SCHOOL
About 25% of school students in Europe encounter bullying, physical fighting or attacks. This poses serious risks to their overall health and well-being and decreases their academic performance. Generic anti-bullying policies do not always lessen bullying towards LGBTQI+ students. About two in 10 students globally (including those in Europe and central Asia) feel like outsiders at school.

CONTENT AND RELEVANCE OF EDUCATION
In 2018, an average of 40% of learners in European Union and Organisation for Economic Co-operation and Development countries did not fully develop basic skills in reading and mathematics by the age of 15. The rate was even less in lower-middle and low-income countries in Europe. In many cases, the content of learning is outdated, poorly aligned with the rapidly evolving needs of the labour market, and overlooks the development of health literacy, social, emotional and other skills that young people themselves find important for their current and future life.

School curricula in some countries are characterized by stereotypes in representation of ethnicity, gender, sexual orientation and religion. Too often, schools are not prepared to deliver comprehensive sexuality and life-skills education and students do not learn what they need to know to successfully and safely manage the transition to adulthood.

POLICIES AND PRACTICES THAT CAN FACILITATE IMPROVEMENTS
These include:

- recovering educational losses through special programmes and ensuring continuity of education (keeping schools open as long as possible and providing all learners with access to remote education at times of school closure);
- improving the quality of education by delivering relevant subject knowledge and skills that help adolescents become lifelong learners, develop positive relationships, make healthier choices and decisions that affect their lives, find productive work and actively engage in their communities;
- expanding non-formal education opportunities (including in digital space) for adolescents for social and emotional learning, agency and resilience building, and career orientation;
- providing a safe, protective and inclusive learning environment free from violence, bullying, stigma and discrimination;
- considering student perspectives in all policy and practice development, implementation and assessment; and
- ensuring that the most vulnerable and marginalized children and adolescents benefit from good-quality and inclusive education and all young people are supported to find meaningful employment.
MENTAL HEALTH

Adolescence is a critical period of formative growth that affects well-being across the life-course. Half of all mental health problems in adulthood have their onset during or before adolescence. There was little change in the subjective well-being of adolescents in the WHO European Region between 2014 and 2018.

Age, sex and socioeconomic status remain strong determinants of mental well-being, with older adolescents, girls and those in lower-income households experiencing worse outcomes.

Reporting on the proportion of adolescents treated or prescribed medicines for common mental health conditions is highly variable across the Region, with missing or questionable quality of data being an issue. More than 4300 deaths per year (15% of all deaths of young people aged 10–19 years) in the WHO European Region are due to self-harm. The burden of self-harm-related deaths differs across the Region: countries of the Commonwealth of Independent States show 5.91 deaths per 100 000, while those of the EU14 show 2.30 deaths per 100 000. Anxiety and depression are among the top-five causes of overall disease burden.

Youth mental health policies and services are often non-existent or underdeveloped. When adolescents are not guaranteed confidential, independent access to adolescent-friendly health-care services, they may delay or forgo seeking necessary services. This can lead to higher rates of unprotected sex, unintended pregnancy, untreated sexually transmitted infections and mental health issues.

Mental illness can lead to worse educational outcomes, increased substance use and higher rates of unemployment, debt and social exclusion in adulthood.

The burden of disease attributable to mental health is not equal between males and females. The proportion of the disability-adjusted life-years (DALY) burden due to self-harm is greater among 15–19-year-old males than females (6.8% versus 2.9%). Females’ DALY burden tends to be greater for causes relating to mental health and somatic complaints (particularly headache, and anxiety and depressive disorders). Collectively, these are responsible for 24% of the DALY burden for 15–19-year-old females, compared to 13% among their male peers.

Evidence is growing about the mental health impacts of the SARS-CoV-2 pandemic and the restrictions on adolescents resulting from measures taken to control the virus. As a result, primary prevention, early intervention and access to appropriate mental health care are even more urgent.

NUTRITION AND PHYSICAL ACTIVITY

Adolescent overweight and obesity are serious public health problems of the 21st century and are important risk factors for noncommunicable diseases. One in five (20%) adolescents aged 11–15 years in the WHO European Region is overweight or obese.

Adolescents living with overweight and obesity experience stigma, which is associated

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9 Countries belonging to the European Union since before 2004.
with physiological and psychological consequences including increased depression, anxiety and decreased self-esteem. Physical inactivity is related to obesity: fewer than one in five adolescents aged 11–15 years achieve the recommended physical activity levels and participation among girls and older adolescents is particularly low.

Social inequalities in adolescent obesity, overweight and in physical activity exist within and across countries, with adolescents from poorer families more likely to be overweight, obese and physically inactive. Most adolescents do not meet current nutritional recommendations, consuming too few fruits and vegetables and having high intakes of sugar-sweetened beverages.

Both underweight (5% in the WHO European Region) and overweight undermine adolescents’ capacity for healthy development and can lead to serious health, educational and economic consequences. Over- and undernutrition are caused by various factors, including genetic, environmental, metabolic, behavioural, mental, cultural and socioeconomic.

Changing behaviour is difficult and is influenced by factors such as income, cost, time, individual preferences, beliefs, family and cultural traditions, and geographical and environmental factors. A triple burden of malnutrition in adolescence, in which countries experience simultaneous challenges of underweight, hidden hunger and overweight, exists.

The average prevalence of moderate or severe food insecurity\textsuperscript{10} for 41 countries of the WHO European Region is 12%. Children and adolescents have access to digital devices early in life. Increased screen time is associated with increased risk of overweight and obesity.

POLICIES IN RELATION TO NUTRITION AND PHYSICAL ACTIVITY
Health should be considered in all policy-making, regardless of the sector (such as education, economic or travel), with a collaborative approach being integral to improving the health of all young people and communities. The marketing of unhealthy foods and sugar-sweetened beverages to children is linked to overweight and obesity. WHO-endorsed policy recommendations aim to reduce marketing of high-fat, high-sugar foods and beverages. Not all countries of the European Region restrict marking to children and very few restrict online marketing via mobile phones and gaming platforms. Thirty-one (out of 53) countries of the Region regulate the availability of unhealthy foods in schools.

Overall, 57% of Member States have national physical activity guidelines in place for children and adolescents. Food insecurity is higher in countries without national nutrition policies and national public awareness campaigns concerning diets.

EXISTING APPROACHES TO PROMOTING HEALTHY DIETS AND PHYSICAL ACTIVITY
Programmes that target both the environment (through, for example, the provision of healthy, sustainable and nutritious food, safe neighbourhoods, and opportunities for physical activity and sports participation) and critical periods during the life-course are required and could help reduce social inequalities. Efforts are needed to promote habitual daily physical activity by, for example, increasing opportunities for school-based activity, active transportation and active leisure among adolescents.

\textsuperscript{10} Food security is when all people, at all times, have access to safe, sufficient and nutritious foods.
ADOLESCENTS TAKING THE LEAD

The demand and supply sides can be influenced:

- demand-side approaches would include educational policies, promoting awareness and cooking skills; and
- supply-side approaches regulate the industry through policies, taxes, incentives for reformulation of products, development of standards and implementation of recommendations.

The use of national guidelines is important for countries to guide policy-makers and inform the public about healthy behaviours. Monitoring and surveillance systems are crucial to assess behaviours and outcomes and implementation of policies/programmes.

RELATIONSHIPS AND CONNECTEDNESS

Connectedness, positive relationships and values and making a contribution to society are among the key factors that contribute to the emotional and social well-being of adolescents. For adolescents to thrive and achieve their full potential across the life-course, it is important to: feel connected and have positive, meaningful relationships with others, including family, teachers, peers and employers;

- have interpersonal skills such as empathy, sensitivity and friendship skills and have positive social networks;
- be valued and respected by others (their voices are heard and opinions taken seriously) and be accepted (feel belonging to a group/community);
- have positive values, including respect for others, being responsible and caring, and having a sense of integrity, honesty, social justice and equality; and
- have opportunities to be socially, culturally and civically active, engaged in school, youth and community activities, and make changes for themselves and their communities.

Where young people feel connected with parents, peers, schools and communities, feel safe, respected and accepted, and contribute to their families and communities, they are more likely to acquire the social capital needed to achieve life goals and better health and well-being. Among the building blocks for connectedness, positive relationships and values and making a contribution to society are:

- positive parenting and supervision;
- non-parental mentors and role-models;
- a safe and enabling learning environment free from bullying and discrimination;
- social and emotional learning curricula and extracurricular opportunities that develop agency, self-esteem and self-confidence, and empower and build resilience;
- positive values and norms being cherished and practised in family, school and community; and
- opportunities for volunteering, which are associated with better academic performance, high school completion, fewer problem behaviours and greater life satisfaction.

According to the latest Health Behaviour in School-aged Children survey, 11 most adolescents in the WHO European Region experience positive social relationships and overall good health and well-being. Adolescents from poorer backgrounds, however, experience less social support from family, friends and classmates. Social and emotional well-being decreases as adolescents get older, especially among girls.

11 The survey was conducted in 2017/2018 in 45 countries and regions of Europe and Canada among adolescents aged 11, 13 and 15.
FAMILY CONTEXT
Parental unemployment and immigrant status each affect one in 20 adolescents (5%). Both are risk factors for poorer adolescent health and well-being outcomes. Adolescents from less well-off families experience poorer health and well-being. Parental unemployment, poverty, domestic violence and substance misuse undermine parent-adolescent connectedness.

FAMILY AND PEER COMMUNICATION AND SUPPORT
Adolescents from more affluent families have higher levels of family support, better communication with their parents and higher levels of peer support (64% versus 56%). Over two in three adolescents perceive their parents as being highly supportive and easy to talk to, but these positive aspects of family life decline with increasing age, especially among girls. Most adolescents find it easier to communicate with their mothers (87% boys, 84% girls) than with their fathers (79% boys, 65% girls). Only 57% of 15-year-old girls find it easy to talk to their father about things that bother them.

SCHOOL EXPERIENCE
More than half of adolescents report high levels of support from their fellow students (59%) and their teachers (56%). Levels of peer support have declined slightly since 2014, especially for girls. Only around a quarter (27%) of adolescent boys and girls like school a lot. School experience worsens with age in most countries/regions.

School satisfaction and support from teachers and classmates decline (more steeply among girls) and schoolwork pressure increases with age. Young people from poorer families are less likely to feel supported by their classmates. More than one in 10 students are being bullied in school; girls are more likely to be cyberbullied. Younger adolescents are particularly at risk of being bullied.

LIFE SATISFACTION
Most adolescents feel satisfied with their lives. Adolescents from high-affluence families report higher levels of life satisfaction and excellent health, and lower levels of multiple health complaints. Boys report higher life satisfaction than girls. Life satisfaction decreases with age, more in girls than in boys.

POLICIES AND PRACTICES THAT CAN FACILITATE IMPROVEMENTS
These include:
- supporting families and teaching positive parenting skills;
- increasing opportunities for social interactions in schools and local communities, including youth and volunteer programmes;
- targeting older adolescents, girls and those from lower social strata;
- engaging students and families in school life;
- fostering a safe, positive and inclusive learning environment, with trusting and caring relationships;
- developing social and emotional (relationship) skills;
- guiding students towards values of tolerance and respect;
- providing comprehensive sexuality education; and
- making good-quality, accessible, equitable, acceptable and appropriate psychosocial support and mental health services (including school-based) available to adolescents.
SEXUAL AND REPRODUCTIVE HEALTH

Sexual and reproductive health is fundamental to overall health and well-being. Adolescence is an opportune time to build healthy habits and lifestyles relating to sexual and reproductive health, as it is a period of ongoing physical, emotional and social change, and also the time when many individuals will start exploring their sexuality and developing relationships with others.

KEY FINDINGS

Knowledge and education: most countries in the WHO European Region (37) have a policy on sexuality education in schools, but only 26 collect information on adolescents’ knowledge of sexuality. Fewer than half of countries provide education on LGBTQI+ issues. Most (31) include sexual-/intimate-partner violence, but the depth and quality varies between countries.

Violence: intimate-partner violence (IPV) is the most common form of violence faced by adolescent girls. Nearly one in three adolescent girls aged 15–19 globally reports having ever experienced emotional, physical or sexual IPV. Full, free and informed consent to sexual behaviour is a key issue for education.

Sexual behaviour: there are big differences in the rates of sexual intercourse across countries. Overall, at age 15, 24% of boys and 14% of girls have had sex, but 25% of those did not use either a condom or contraceptive pill the last time they had sex. On average, 26% reported using the pill and 61% a condom at last intercourse.

Contraception: access to contraception without parental consent is possible in most countries (33), with the lower age limit generally between 14 and 16 years. Access to emergency contraception without parental consent is possible in most countries (32), but age limits vary widely. Emergency contraception is free for adolescents in 16 countries. School nurses are not allowed to give out contraceptives without a doctor’s prescription in most countries (34). Only five countries allow school nurses to provide emergency contraception without a prescription.

Pregnancy: adolescent pregnancy rates vary hugely between countries, with some being above the global average. In countries where boys use contraceptives less frequently, adolescent pregnancy rates are higher. In general, the further east, the higher the rate of adolescent pregnancy. Most countries show a plateauing or slight declining trend.

Abortion: abortion rates have declined and currently are three times lower than in 1994. Abortion nevertheless is still overutilized as a birth-control method, particularly in the east. In some countries, abortion is not legally permitted for girls, or is restricted. The barriers to safe abortion increase the risk of illegal abortion-related complications and early parenthood.

Early parenthood: despite decreases since 1990, the adolescent fertility rate (15–19) in the eastern Europe and central Asia (ECCA) region remains high. A loss of early education, together with early marriage and pregnancy, perpetuates a cycle of poverty and gender inequality for many generations. This vicious circle can be broken only by promoting sexuality education in schools, offering easy access to counselling, reliable contraception and promoting women’s empowerment.
**HIV:** countries in the ECCA region have one of the world’s fastest-growing HIV epidemics. Young people are particularly vulnerable to HIV, driven by poor sexuality education and lack of access to condoms.

**Sexual and reproductive health services:** free services are provided to adolescents in most countries (34), and 32 countries provide testing for sexually transmitted infections (STIs) free to adolescents. Laws and regulations on the confidentiality of access to STI treatment vary widely; only 14 countries legally ensure confidentiality while accessing treatment for STIs. Parental consent rules deter adolescents from seeking health care and advice.

**Minorities at increased risk:** adolescents who are part of the LGBTQI+, Roma or migrant communities, young people living with disabilities or illness and those not in school can be disproportionately vulnerable because of discrimination and lack of education and access to services. Girls are particularly vulnerable to violence.

**KEY ISSUES**

- Adolescent sexuality is considered a sensitive issue in some countries of the WHO European Region.
- Inequities in provision of, and access to, sexual and reproductive health services and information still exist in the European Region. Countries of the ECCA region are behind European Union countries in most areas of adolescent and youth sexual and reproductive health and rights. Accordingly, the gaps and needs in EECA countries are more significant.
- There is no information on the quality of sexuality education provided, though standards for sexuality education in Europe, including guidelines for the introduction of comprehensive sexuality education in countries, have been developed.
- All adolescents should have comprehensive education on contraceptive methods, consent and violence, have the freedom to make informed decisions and have access to the most suitable form of contraception for them.
- All adolescents need full access to appropriate and confidential sexual and reproductive health-care services.

To implement the targets that all countries have already signed up to, improve access to sexual and reproductive health services and the use of contraceptives, and reduce adolescent pregnancy rates and transmission of STIs, adolescents should be able to access information and care without the need for parental consent. Gender- and age-appropriate sexuality education, which includes sexual and gender diversity, consent and IPV, is required to enable adolescents to make informed decisions regarding their sexual and reproductive health. Confidentiality and accessibility must be ensured for adolescents who seek sexual health services.
## ANNEX 2: AGENDA

**Day 1, 6 July**

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<tr>
<th>Time</th>
<th>Session</th>
<th>Presenter(s)</th>
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<tr>
<td>10:00–10:10</td>
<td><strong>Opening and welcome</strong></td>
<td>Natasha Azzopardi, Muscat, WHO Regional Office for Europe;</td>
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<td><strong>Objectives, expected outcomes and review of agenda</strong></td>
<td>Martin Weber, WHO Regional Office for Europe</td>
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<td>10:10–10:25</td>
<td><strong>Session 1. Plenary</strong></td>
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<td><strong>Objective:</strong> to introduce all participants to the process, background papers, ideas, strategies, complemented by regional work</td>
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<td>10:10–10:25</td>
<td><strong>Adolescent well-being: global perspective</strong></td>
<td>Valentina Baltag, WHO headquarters</td>
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<td>● Global call to action</td>
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<td>10:25–10:40</td>
<td><strong>Adolescent well-being: regional perspective</strong></td>
<td>Martin Weber; Parmosivea Soobrayan UNICEF; Tigran Yepoyan, UNESCO</td>
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<td>10:10–10:25</td>
<td><strong>Introduction to group work</strong></td>
<td>Aixa Alemán-Díaz, Vivien Hülsen, WHO Regional Office for Europe</td>
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<td>10:10–10:25</td>
<td><strong>Session 2. Breakout sessions</strong></td>
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<td><strong>Objective:</strong> six parallel sessions covering six topics; participants answer three questions in relation to their topic</td>
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<td>10:10–10:25</td>
<td><strong>Group work in breakout sessions</strong></td>
<td>Sessions facilitated by the members of the regional technical working group</td>
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<td>Breakout sessions cover the following topics:</td>
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<td>● mental health</td>
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<td>● nutrition and physical activity</td>
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<td></td>
<td>● relationships and connectedness</td>
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<td></td>
<td>● sexual and reproductive health</td>
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<tr>
<td>11:55–12:00</td>
<td><strong>Session 3. Plenary, closing of day 1</strong></td>
<td></td>
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<td></td>
<td><strong>Objective:</strong> wrap up of day 1</td>
<td></td>
</tr>
<tr>
<td>11:55–12:00</td>
<td><strong>Closing remarks for day one</strong></td>
<td>Martin Weber; Rune Brandrup, UNFPA</td>
</tr>
</tbody>
</table>
### Opening session

Day 2, 7 July

<table>
<thead>
<tr>
<th>10:00–10:10</th>
<th>Opening of day 2</th>
<th>Parmosivea Soobrayan; Martin Weber</th>
</tr>
</thead>
</table>

### Session 4. Working groups continued

**Objective:** to finalize working group outcomes in the same breakout sessions and prepare a five-minute presentation on the three questions to be presented in plenary.

<table>
<thead>
<tr>
<th>10:10–10:30</th>
<th>Working groups in six breakout sessions</th>
<th>Sessions facilitated by the members of the regional technical working group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Finalization of the breakout sessions of day 1</td>
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</table>

### Session 5. Plenary

**Objective:** to present and comment on outcomes of breakout sessions; five minutes per group

**Wrap up of the consultation.**

<table>
<thead>
<tr>
<th>10:30–11:30</th>
<th>Presentations of working group outcomes</th>
<th>Tigran Yepoyan</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>1. Digitalization</td>
<td>Tigran Yepoyan</td>
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<td>2. Education</td>
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<td>3. Mental health</td>
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<td>4. Nutrition and physical activity</td>
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<td>5. Relationships and connectedness</td>
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<td>6. Sexual and reproductive health</td>
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<thead>
<tr>
<th>11:30–11:50</th>
<th>Summary of outcomes</th>
<th>Nina Ferencic, UNICEF</th>
</tr>
</thead>
</table>

### Closing of the meeting

<table>
<thead>
<tr>
<th>11:50–12:00</th>
<th>Closing remarks</th>
<th>Martin Weber; Artemis Tsitsika; Tigran Yepoyan; Nina Ferencic; Rusian Malyuta, UNICEF; Parmosivea Soobrayan; Rune Brandrup; Valentina Baltag</th>
</tr>
</thead>
</table>
ANNEX 3: PARTICIPANTS

Youth representatives

Daria Ambroci
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Republic of Moldova

Cristina Caldari
Youth Klinik Neovita
Republic of Moldova

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Escola Secundária Pedro Alexandrino
Portugal

Niki Viktória Iliopoulos
Slovakia

Maria Jaworska
Council for Dialogue with The Young Generation
Poland

Mihail Lesco
Youth Clinic
Republic of Moldova

Gonçalo Marques
Portugal

Shukurgeldi Myradov
Interregional Network of the UN Preventive Diplomacy Ambassadors
UN Regional Centre for Preventive Diplomacy for Central Asia
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Y-PEER
Turkmenistan

Selbi Atakishiyeva
Y-PEER
Turkmenistan

Manuel Ferreira
Colégio de Nossa Senhora da Paz
Portugal

ZohreGeldyyeva
Y-PEER
Turkmenistan

Alexandra Ivasenková
Slovakia

Martyna Łuszczyk
Young Club for Poland
United Kingdom

Tadhg Magill
Ireland

Sergey Mkhitaryan
Armenia

David Pini
Lycée Français Victor Hugo de Francfort
Germany

Dana Zhamalbek
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Experts

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Centre for Human Reproduction
Youth Health Centre
Kazakhstan

Kirill Khomov
RANEPA
Russian Federation

Amelia Lake
Teesside University, Public Health Nutrition
United Kingdom
<table>
<thead>
<tr>
<th>Name</th>
<th>Institution/University</th>
<th>Country</th>
</tr>
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<tbody>
<tr>
<td>Galina Lesco</td>
<td>National Resource Centre in YFHS Neovita</td>
<td>Republic of Moldova</td>
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<tr>
<td>Marta Malinowska-Cieślil</td>
<td>Jagiellonian University</td>
<td>Poland</td>
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<tr>
<td>Johanna Marquardt</td>
<td>BZgA</td>
<td>Germany</td>
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<tr>
<td>Narissia Mawad</td>
<td>Consultant</td>
<td>France</td>
</tr>
<tr>
<td>Antony Morgan</td>
<td>Glasgow Caledonian University</td>
<td>United Kingdom</td>
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<tr>
<td>Orkan Okan</td>
<td>Bielefeld University</td>
<td>Germany</td>
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<tr>
<td>Iveta Pudule</td>
<td>Unit of NCD Data Analysis and Research</td>
<td>Latvia</td>
</tr>
<tr>
<td>Scarlett Rodrigues</td>
<td>National University of Ireland Galway</td>
<td>Ireland</td>
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<tr>
<td>Sergey Sargsyan</td>
<td>Arabkir Medical Centre – Institute of Child and Adolescent Health</td>
<td>Armenia</td>
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<tr>
<td>Colette Kelly</td>
<td>National University of Ireland Galway</td>
<td>Ireland</td>
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<tr>
<td>Elen Khosteghyan</td>
<td>Teenslive</td>
<td>Armenia</td>
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<tr>
<td>Kathrin Lauber</td>
<td>University of Bath</td>
<td>United Kingdom</td>
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<tr>
<td>Alfiya Maksutova</td>
<td>Dvor</td>
<td>Russian Federation</td>
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<tr>
<td>Marina Melkumova</td>
<td>Arabkir Medical Centre – Institute of Child and Adolescent Health</td>
<td>Armenia</td>
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<tr>
<td>Emily Mates</td>
<td>Emergency Nutrition Network</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Fiona Mansergh</td>
<td>Department of Health and Wellbeing</td>
<td>Ireland</td>
</tr>
<tr>
<td>Wendy Nicholson</td>
<td>Public Health England</td>
<td>United Kingdom</td>
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<tr>
<td>Natalia Pashko</td>
<td>Institute of Health Psychology</td>
<td>Ukraine</td>
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<tr>
<td>Divya Ravikumar</td>
<td>National University of Ireland Galway</td>
<td>Ireland</td>
</tr>
<tr>
<td>Tatiana Salisbury</td>
<td>King’s College London</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Anette Schulz</td>
<td>Schools for Health in Europe</td>
<td>Denmark</td>
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<tr>
<td>Eileen Scott</td>
<td>Public Health Scotland</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Tetiana Slobodian</td>
<td>Woman Health and Family Planning</td>
<td>Ukraine</td>
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<tr>
<td>Marjorita Sormunen</td>
<td>University of Eastern Finland</td>
<td>Finland</td>
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<tr>
<td>Mimi Tatlow-Golden</td>
<td>The Open University</td>
<td>United Kingdom</td>
</tr>
<tr>
<td>Veronica Velasco</td>
<td>Milano-Bicocca University</td>
<td>Italy</td>
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</tbody>
</table>
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Bobby Soobrayan
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Consultant
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Elena Shevkun
Technical Officer
Mental Health

Martin Weber
Programme Manager
Child and Adolescent Health and Development

Aixa Aleman-Diaz
Consultant

Mirjam Heinen
Consultant

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**United Nations Educational, Scientific and Cultural Organization**

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Regional Advisor for health and Education,
Eastern Europe & Central Asia
Russian Federation

Edward Tulokhonov
UNESCO IITE
Russian Federation

**United Nations Children's Fund**

Nina Ferencic
Adolescent health

Ruslan Malyuta
HIV specialist
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