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**GLOBAL CONSULTATION ON ADOLESCENT
FRIENDLY HEALTH SERVICES
A CONSENSUS STATEMENT**

GENEVA, 7-9 MARCH 2001



Department of Child and Adolescent Health and Development
World Health Organization

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GLOBAL CONSULTATION ON ADOLESCENT FRIENDLY HEALTH SERVICES A CONSENSUS STATEMENT

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A brief report, a presentation of consensus statements,
the evidence-base for these statements, and their implications for action.



Department of Child and Adolescent Health and Development,
World Health Organization

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The valuable contributions of many individuals and organizations, to the extended consultative process which culminated in the global consultation on adolescent friendly health services, is gratefully acknowledged. They included those directly working with/serving adolescents and those working for bilateral agencies, international NGOs and United Nations agencies which provide support for adolescent health and development work. (Please refer to section 5 for the list of participants). Special thanks are due to Loretta Brabin for preparing the review and discussion paper which was tabled at the consultation, and for working to incorporate the many comments and questions that were raised. Thanks are also due to John Howard and John Townsend for their assistance in facilitating the discussions and debates at the consultation.

A NOTE ON TERMINOLOGY USED

Adolescence: WHO defines adolescence as the second decade of life, the period between the ages of 10 and 19. However, it must be stressed that adolescence is a phase, rather than a fixed time period in an individual's life. A phase during which enormous physical and psychological changes occur, as do changes in social perceptions and expectations. A phase when an individual is no longer a child, but not yet an adult.

Health service and health facility: In this document, the term health service is used to refer to the provision of a clinical service, which often includes some information provision and advice aimed at preventing health problems, or detecting and treating them. It is distinct from the term health facility, which is used to refer to a recognised institution that provides health services. Health facilities can range from small clinics (providing a limited range of primary level services), to large hospital complexes (providing a range of tertiary level health and social services).

ABBREVIATIONS USED

AIDS - Acquired Immuno Deficiency Syndrome
 IDRC - International Development Research Centre
 NGO - Non Governmental Organization
 PAHO - Pan American Health Organization
 STI - Sexually Transmitted Infections
 TDR - Special Programme for Research and Training in Tropical Diseases
 UNAIDS - United Nations Programme on AIDS
 UNDP - United Nations Development Programme
 UNICEF - United Nations Children's Fund
 UNFPA - United Nations Population Fund
 WHO - World Health Organization

TABLE OF CONTENTS

1.	The global consultative process	6
2.	The consensus statements emanating from the global consultation	7
3.	The evidence-base for the consensus statements, and their implications for action	8
4.	References	23
5.	List of participants at the global consultation	26

I. THE GLOBAL CONSULTATIVE PROCESS

In 1995, WHO organized a study group on programming for adolescent health and development along with UNICEF and UNFPA. This resulted in the development of a 'Common Agenda for Action' on adolescent health and development, endorsed by the three agencies. The Common Agenda called for the application of a package of 'actions' by a variety of 'players', to promote healthy development in adolescents and to prevent and respond to health problems if and when they arise. The 'actions' include:

- the creation of a safe and supportive environment
- the provision of information
- building life-skills
- the provision of health and counselling services.

The 'players' include those in close contact with adolescents such as their parents, other family members, family friends, teachers and religious leaders. They also include musicians, film stars and sports figures who have a tremendous influence on them from afar. The Common Agenda stresses that adolescents too have an important role to play.

Following the study group meeting, WHO took on research and development work in the area of health service provision in earnest. Over a five year period, from 1996 to 2001, reviews of the published and unpublished literature were carried out, case studies of outstanding initiatives from around the world were gathered and synthesized, and operations research initiatives were stimulated and supported in a variety of settings and contexts. A tremendous amount of ground was covered, and much learning done. To begin the process of distilling the many lessons that had been learned - both by WHO and by many organizations working on the 'front line', two regional consultations were organized - one in Latin America (Costa Rica, September 2000) and the other in Africa (Harare, October 2000). Building on the conclusions and recommendations of these consultations, and those of international conferences held elsewhere, WHO worked with

its partners within and outside the United Nations system to organize a global consultation on adolescent friendly health services (in March 2001).

The rationale for the global consultation was as follows. By the end of the 1990s, there was growing acknowledgement that the health of adolescents was an important issue in the public health concern, in both developed and developing countries. There was, by that time, a tremendous interest in the area of health service provision to adolescents. A range of bilateral agencies, international NGOs and United Nations agencies were stimulating and supporting country level action in this area. There appeared, in our assessment, a real need for the development of a shared understanding in this area. This is what the global consultation on Adolescent Friendly Health Services set out to do. Its objectives were as follows:

1. To develop a common understanding of the health and development needs and problems of adolescents; their help-seeking behaviours; the role and contribution that health services could make to their health and well being; and the prevailing situation - in different parts of the world - in terms of the availability and accessibility of health services to adolescents.
2. To define best practices in what could be done to enhance the quality of health services and to deliver them in a user-friendly manner, within the economic and socio-cultural constraints that exist in many parts of the world.
3. To develop a consensus on a global research and action agenda in making it easier for adolescents to obtain the health services they need (which are of good quality).

The global consultation brought together representatives from over 20 countries who were directly and currently involved in providing health services to different groups of

adolescents in their respective countries. They represented both the government and the non government sectors. They were joined by staff from several United Nations agencies, bilateral agencies and international NGOs.

As part of the preparatory work for the meeting, a comprehensive search of the published and unpublished literature was carried out, and - to fill important gaps - case studies were commissioned. Every effort was made to draw upon both research evidence and the experience of front-line workers from around the world. Based on this wealth of information, experiences and insights, a substantive review and discussion paper was prepared, and circulated to invited participants, in advance of the meeting.

The discussion at the three day meeting was organised around key themes that emerged from the working paper. Following a short set of 'mini presentations' relating to each theme, there was frank and animated discussion in plenary. Alongside these plenary sessions, time was set aside for smaller regional meetings to provide an opportunity for more focused discussion on issues of interest and concern.

Over the three day period, a shared understanding on various aspects of adolescent health and development emerged. Participants worked together to develop ten consensus statements, and set out the implications of this for action both at the international and national levels. Their conclusions and recommendations have been outlined in subsequent sections of the document.

II. THE CONSENSUS STATEMENTS EMANATING FROM THE GLOBAL CONSULTATION

The following ten statements emanated from the global consultation on Adolescent Friendly Health Services.

- 1: Promoting adolescent health and development requires a shared vision with complementary actions by different players; actions which are aimed at fulfilling their rights, and address their special needs.
- 2: All adolescents should be able to access promotive, preventive and curative health services relevant to their stage of maturation and life circumstances.
- 3: For a variety of reasons, adolescents in many places are unable to obtain the health services they need.
- 4: Adolescents have many ideas about how to make services user-friendly; generally they stress the ethos more than the technical quality of the services.
- 5: A user-friendly health service does not necessarily ensure service utilization by adolescents.
- 6: There are a number of approaches for increasing service utilization by adolescents (in places where a user-friendly health service exists).
- 7: To complement and extend coverage of government-run health facilities for adolescents, other channels could be made available. Adolescents are much more likely to obtain the services they need if existing service-providers are networked.
- 8: It would be helpful to define the elements of a core package, and how it could be developed and provided in different settings/contexts.
- 9: Health care providers require technical competence relevant to adolescent health and development.
- 10: Quality assurance/improvement methods, which empower health care providers to deliver client-centred care, should be applied to health services for adolescents.

III. THE EVIDENCE-BASE FOR THE CONSENSUS STATEMENTS, AND THEIR IMPLICATIONS FOR ACTION

1: Promoting adolescent health and development requires a shared vision with complementary actions by different players; Actions which are aimed at fulfilling their rights and address their special needs.

EVIDENCE:

Promoting healthy development includes meeting the needs, acknowledging the rights and building the competencies of individuals as they move from childhood through adolescence to adulthood (UNICEF, 1997). Adolescents should be assured of: physical health, mental and emotional well-being, freedom from exploitation and abuse, and skills and opportunities for sustainable livelihoods. They also have the right to participate in decisions and actions that affect their lives, and in being involved, to develop roles and attitudes compatible with responsible citizenship (WHO, 2000a).

A Common Agenda for Action agreed upon by WHO, UNFPA and UNICEF (1997a) outlined the actions needed to provide adolescents with support and opportunities to:

- Live in a safe and supportive environment,
- Acquire accurate information about their health and development needs,
- Build the life skills they need to protect and safe guard their health,
- Obtain counselling services,
- Have access to health services.

To achieve this agenda will require different and complementary actions by a variety of players, including parents, families and communities (which provide a protective and nurturing environment); private and civil organizations (which can be more responsive to an adolescent perspective); and government (which legitimizes the action of different sectors through political will).

Policy makers and politicians do not always appreciate that adolescent health contributes to general development, just as investment in adolescents' education and employment contributes to health. One result is a lack of a

common vision leading to supportive policies and effective programmes for adolescent health and development. WHO has stressed that promoting the healthy development of young people in the second decade of life is one of the most important investments that any society can make. It has also warned that the social and economic costs of failing to do so are enormous (WHO, 1998c, PAHO, 1998).

IMPLICATIONS:

Only two countries have yet to ratify and implement the Convention on the Rights of the Child. Even in all the others which have, there are often infringements which result in exploitation, violence and prejudice. Adolescent health should be addressed in the context of the Convention, respecting the prevailing political circumstances, the level of health policy development and assessing why, in each country, adolescents may need protection. More effective methods and tools are required to measure the performance of countries which have signed the Convention. They would be useful for assessing the progress of country level actions in promoting adolescent health and development.

Political will should be fostered through advocacy until a common vision of adolescent health and development is engendered, agreed and applied across government, private and civil organizations. It will be necessary to define the roles, responsibilities and mechanisms to operationalize the adolescent vision through planning and task assignment. All countries should sharpen their focus on adolescents in health sector reform, programme planning and resource management, health system and personnel performance appraisal, and in the creation of conditions that allow young consumers to express a demand for health information and services. The roles of the media, the formal education system and organizations fostering adolescent participation

need to be enhanced as part of this process. This will help to overcome prejudice, understand sexuality, prevent violence, foster respect for others and match rights to responsibilities.

The enormous benefits of investing in adolescents, and harnessing their health and energy, are often unappreciated. The cost effectiveness of financial investment in adolescent development and the long-term efficiency of making health services available and accessible to young people need to be better articulated. Greater investment in preventive actions, as well as access to curative and rehabilitative care at the adolescent stage is needed. Those working with adolescents

believe that that this will result in a healthier adult population. However, as noted in a report on the mental health needs of Canadian adolescents, "We continue to strive and advocate at the national and provincial level. However the climate of fiscal restraint, the waves of major re-organization of services and health authorities, and the prevailing sentiment that health care is in crisis, tend to overwhelm the longstanding unmet ... needs of Canadian adolescents. It remains a challenge to counterbalance a climate in which Adolescent Friendly Health services are seen as "a frill" (Tonkin, 2000). What this means is that concerted efforts are needed to sensitize and to educate policy makers, planners and programme managers.

2: All adolescents should be able to access promotive, preventive and curative health services, relevant to their stage of maturation and life circumstances

EVIDENCE:

Adolescents pass through well-described physical, psychological and sexual maturation stages (Tanner, 1962). Based on this understanding of adolescent development and health, the American Medical Association has proposed a comprehensive set of promotive and preventive health actions - which includes psycho-social assessment, physical examination, information provision and immunization (Elster and Kuznets, 1992). Some of these actions have also been recommended for developing countries (Brabin, 2000). How adolescence is experienced and the health risks faced vary, amongst other things, with age, sex, marital status, socio-cultural context and economic circumstances.

For some adolescents, this a period of psycho-social stress which can, in extreme cases, result in illnesses and injuries (including self inflicted ones). In Western countries, for example, the general health of adolescents is good, but there are significant problems in areas such as mental health and eating disorders (Neumark-Sztainer and Hannan, 2000). Here too, there are increasing numbers of adolescents who are homeless or in care, or who have problems related to substance use (Howard, 2000; Tonkin, 2000).

In many developing countries the focus has been more on physical health on account of the heavy burden of disease borne in these countries (WHO, 1995). Earlier sexual maturity, the HIV/AIDS pandemic, the increased availability of tobacco, alcohol and other psychoactive substances, growing - absolute and relative - poverty and conflict (including wars and civil strife) are leading to increasing trends of poor development and ill-health among adolescents (International Center for Research on Women, 1994). The resources available for curative health are limited and non-acute conditions or behavioural issues do not receive a high priority.

Patterns of health and illness in male and female adolescents show marked differences. In most parts of the world, young men run a greater risk than young women of dying from accidents and violence; and smoking, which often starts in adolescence, contributes to the higher numbers of male deaths from coronary heart diseases (WHO, 2000b). Nutritional deficiencies such as anaemia, and menstrual disorders such as menorrhagia and dysmenorrhoea (Barr et al, 1998) become evident in girls/young women during adolescence but are rarely taken seriously because they are not usually life-threatening. The susceptibility of young women to problems resulting from too early, unprotected and

unwanted sexual activity is very well recognized (WHO, 1998a; Alan Guttmacher Institute, 1998). In many cultures it is not acceptable to discuss sex or topics such as menstruation, and sex outside of marriage is neither condoned nor excused. As a result married adolescents can “legitimately” access reproductive and sexual health services denied to unmarried ones. If pregnancy does occur outside of marriage, girls/young women tend to suffer physically and emotionally far more than boys/young men.

During adolescence, individuals gradually assume responsibility for their own health (Crocket & Petersen, 1993), but support during this process may be needed. Young adolescents are a particularly vulnerable group, (FOCUS, Jan. 2000), but their access to information and services is often restricted by parents. With increasing age and independence, many adolescents become sexually active and experiment more - with tobacco and other psychoactive substances. Obviously, there are enormous variations in the patterns of this in different social and cultural settings (Erulkar et al, 1998; Elder et al, 2000). Many adolescents pass through this stage with no adverse consequences, but generally, the younger these behaviours start, the more potential there is for adverse outcomes. Risk-taking behaviours cluster, and this is thought to reflect particular life circumstances in which appropriate support structures for adolescents are absent, or which predispose to risk taking (Simantov et al, 2000). Adverse outcomes related to sexual behaviour, such as unwanted pregnancy and STIs, are likely to be reduced when adolescents have access to information and counselling, and to contraception and STI treatment.

Some adolescents fare worse because of personal circumstances. Some are exploited, sexually and physically abused, some sell sex because of financial insecurity. Some live in disrupted families, affected by AIDS, civil disruption or an emergency situation and are deprived of basic necessities or emotional support (International Center for Research on Women, 1996). The terms Children in Difficult Circumstances and Especially Vulnerable Young People have been coined by UNICEF

and UNAIDS respectively, to draw attention to the special needs and problems of these children/adolescents.

IMPLICATIONS:

Some of the services adolescents require are different from those provided for adults or for children – having a greater emphasis on information, psycho-social support, promotive and preventive health services - as is appropriate for a maturing population. There is not always agreement on what is appropriate for young adolescents and in reality, the clientele will have wide ranging and varied needs. A guide to developmentally based interventions and strategies is being produced (FOCUS; unpublished draft document).

In general, service providers have less experience in providing preventive and promotive services, and preventive health is often given a lower priority than curative services. It has been observed, even in a well-developed country such as Sweden (Asp, 2001), that when finances are short, priorities shift from prevention to curative services.

The challenge is to find a mode of service delivery which is responsive to the adolescent group to be served and makes best use of whatever resources are available. In developing countries, health facilities are often overwhelmed with patients and may not be a conducive environment for health promotion. General curative care and treatment of reproductive health problems such as STIs are nonetheless important and can open up channels of communication between health care providers and adolescents. It is for this reason that much of the emphasis has been on “adolescent friendliness”.

The views of health professionals – who focus on medical problems, and adolescents – who may be more concerned about being “normal”, may not always converge. Listening to young peoples’ views and working with their ideas is an important part of the process of defining what services they need and how they could be delivered.

3: For a variety of reasons, adolescents in many places are unable to obtain the health services they need

EVIDENCE:

Adolescents - like children and adults - seek help on different issues from different individuals and organizations around them. Their help seeking behaviour and their health-care seeking behaviour are affected by a web of individual and societal factors (Jejeebhoy, 1996).

Adolescents in many countries are currently deterred from seeking help at health facilities. It appears that they may seek help for common illnesses such as malaria or upper respiratory tract infections. However, they are less likely to use them for sexual and reproductive health complaints, as shown by the low numbers of adolescents attending family planning clinics, or high proportions presenting late for ante-natal care. They are sensitive about seeking help for conditions considered stigmatizing, such as mental health problems, or diseases which affect their appearance or 'marriageability', such as leprosy or filariasis (IDRC/UNDP/TDR, 1992). It is thought that many complaints are treated without consultation, with a rising number of adolescents making use of pharmacies and other sources of help.

Most studies concur that the following factors affect health-seeking behaviour:

- **Motivational factors**

These may reflect:

Individual characteristics: young age, limited experience or knowledge about signs and symptoms of some illnesses, uncertainty about where to seek help, and fear of stigma or embarrassment (e.g. in relation to STIs), and influence of gender considerations.

Community characteristics (including cultural norms): whether, for example, a health problem is considered important and amenable to treatment by modern medicine (e.g. menstrual morbidity is considered unimportant in many places, and mental health problems are considered in some places to be caused by harmful

spirits); whether a health facility is an appropriate source of help (as compared with other sources of help available in the community); and which source of help is considered more suitable for girls/women (Ahmed, 1990).

- **Problems of access**

e.g. cost, inconvenient hours and transportation problems. The cost of services appears to be an important factor. Location is another important one. Some argue that services should be made available close to adolescents' homes, but others suggest that a facility further away offers more anonymity. It is probable that younger adolescents prefer a nearby health facility whereas older adolescents, with a little more money and confidence (perhaps motivated by a previous unsatisfactory experience), may be prepared to go further afield.

- **A negative experience at the health facility**

This is often described as:

being seen by acquaintances, waiting for a long time, cumbersome registration procedures, being refused services, being overheard by others, being humiliated, having a painful examination, poor facilities/services, e.g. shortages of drugs, and unhelpful staff.

IMPLICATIONS:

Many of these factors – such as distance, waiting times, long queues, and low quality services at the point of delivery - affect adult as well as adolescent health care seeking behaviour. In many places this serves to encourage both adolescents and adults to look for help outside the public sector. There is considerable interest among international agencies in strengthening private sector health care provision. Studies are not available which compare adult and adolescent health-seeking behaviours by sex, controlled for different levels of public service provision and legislative restrictions on adolescent access. Nor is it

evident that the quality of services received in the private sector are medically superior to that in the public sector, even if they are socially acceptable to adolescents. This is a serious issue when it comes to appropriate treatment for illnesses such as sexually transmitted infections, which require appropriate and effective management for both individual and public health reasons.

A key factor affecting health-seeking behaviour of adolescents is their ability to obtain sexual and reproductive health services in the public sector. A negative experience often results because a health care provider or receptionist is disapproving or there is ambiguity about the rights of minors to treatment without parental consent. Hence, the

starting point for an adolescent friendly health service should be to reduce the reluctance of health workers to treat adolescents. Doing so will raise a number of issues: firstly, the need for an empowering legal framework – to confirm adolescent rights, and to protect health workers in the event of community disapproval; secondly, health care providers and ancillary staff often lack knowledge and appropriate communication skills to reassure adolescents and make them feel welcome; thirdly, even if legally protected and trained, some health care providers will still be reluctant to provide sexual health service for adolescents on moral grounds; fourthly, attitudes do not change overnight and it will require a sustained effort addressing both providers and recipients of services.

4: Adolescents have many ideas about how to make health services user friendly, generally they stress the ethos more than the technical quality of the services

EVIDENCE:

Characteristics which adolescents have identified as constituting user friendliness in many service audits and surveys in many countries are as follows:

- The facility – its hours and location – should be well advertized, although its entrance should be discrete. Busy shopping centres, small side streets, premises located near schools and colleges or on bus routes, are all favoured. Adolescents often request that services be made available after school hours and at weekends.
- The facility should be comfortable and welcoming (this includes reception staff). Adolescents like to “drop in” to be registered and attended to quickly. They insist on privacy and confidentiality and tend to be put off by requirements for parental consent. They want staff to treat them with respect and not “talk down” to them or judge them. They like to see the same person on return visits.
- They expect plenty of time to talk to a health care provider, lots of information, and all the services they need - under one roof. They are not keen on some kinds of examinations (for instance, examination of the genitals).

- They are often unable to pay for services, but may be motivated to 'beg, borrow or steal' to pay for some services (such as termination of an unwanted pregnancy) and to protect their confidentiality.

Views of particular sub-groups of adolescents have not been systematically explored in this paper - or in the literature (Senderowitz, 1999). It might be anticipated, for example, that different groups of adolescents - males and females, older and younger ones, and specific groups - such as those with certain conditions (diseases or disabilities) or those in particular circumstances (e.g. those 'on the street') would look for some special characteristics.

IMPLICATIONS:

User friendliness is a concept that seems to define a necessary component of any adolescent health service. It must be stressed that it would be difficult to meet all the above criteria. Further a service that addresses the needs and preferences of one group of adolescents may not necessarily do so for all adolescents. Overall, however, two characteristics stand out as paramount - provider attitudes and confidentiality.

5: A user friendly health service does not necessarily ensure service utilization by adolescents

EVIDENCE:

It has been stated that the provision of an apparently friendly service (of good technical quality) does not necessarily result in increased demand for services or affect the reproductive health of the target population. These were the findings of one of very few population-based, as opposed to clinic-based, studies (Hughes et al., 1995) and it related only to family planning services. In that study, service provision was extended but uptake was not increased. Nor did outreach activities and media campaigns increase clinic utilization rates. In spite of some methodological problems (definition of the client target population and sample size), the study was useful in drawing attention to a critical issue which is yet unresolved. If service availability is unrelated, or only weakly related to outcomes such as adolescent fertility, then the problem is clearly greater than the supply of services and is likely to relate to patterns of selectivity in clinic use.

Many different approaches have been tried out to deliver health services to adolescents. Attempts have been made to classify them, as follows (WHO, 1997b; WHO, 1999):

- A health facility specializing in adolescent health and linked to a medical school attached to a hospital. They often serve as a referral centre, and in addition, carry out research and training programmes.
- A community-based health facility that strives to provide 'friendly' preventive and curative health services to adolescents, within the context of health service provision to the community at large. This may be a 'stand-alone' unit (almost always operated by NGOs) or as part of a district or municipal health system (generally run by the government).
- A community-based centre, which is not a health facility, which provides adolescents with some or all the health services they need. Health services may be only one of a range of services provided by these organizations (non-health services might include vocational training and recreation).

These centres are generally run by NGOs and tend to be linked to health facilities nearby.

- Organizations that are involved primarily in outreach information provision/education work, which provide a limited range of health services but actively facilitate referral to health facilities in the vicinity.

There have been many short-term pilot studies but evaluations have not been rigorous enough to determine confidently the components that make a service more or less accessible to adolescents (Senderowitz, 2000). What does emerge from these pilots is that different service models attract different populations of adolescents (Townsend et al, 1987). Age, sex and personal circumstances have proved to be three major factors affecting utilization. What this means is that selectivity in clinic use is an important issue.

Reproductive health services – whether offered in dedicated youth centres or public health facilities - largely attract female clients. In Sweden, where there are youth centres throughout the country, liberal attitudes and few legal barriers to service provision, the majority of patient visits to youth centres run by the county councils are made by females (Asp, 2001). The proportion of males attending has risen from 4% in 1996 to 15% in 2000, and their main reason for attending is chlamydia screening. In most countries, condoms or STI treatment are the main reasons for young men to go to a health facility. NGOs offering specialized reproductive health services have the same experience. Profamilia, the International Planned Parenthood Federation affiliate in Colombia, has seen a steady rise in the use of its health facility based services but over 70% of clients are single women between the ages of 17-19 years (Senderowitz, 2000). A recent variation in delivery style has been the establishment of Adolescent Health Corners (e.g. in Lesotho and Thailand), that are specially earmarked areas within health facilities that cater for adolescents. It is not yet clear whether,

in these locations, young men will attend in larger numbers.

In some countries reproductive health services were integrated with recreation, vocational activities, and/or library facilities in stand-alone youth centres. In these centres the sex ratio was reversed. An assessment by the Population Council (1998) in Kenya, Zimbabwe and Ghana found that these centres became dominated by young men coming for recreational activities, the average age of clients was over 20 years and a low proportion of either sex attended for reproductive health services. These findings have been confirmed elsewhere and suggest that dedicated youth centres are costly to maintain, largely depend on outside sources of funds and seem to have a limited potential to improve reproductive health.

IMPLICATIONS:

It is important to define who (meaning which group of adolescents) the intended users of the health services are, and why, and then to decide which model (or combination of models) will achieve that aim. The US study by Hughes et al (1995) suggests that, if the technical quality of a service is acceptable, clinic attendance rates may stabilise, after which, other approaches will be needed for difficult-to-reach groups. The issue for these groups and individuals may not be lack of a service, but social/psychological factors which stop the adolescent from connecting with the service (e.g. sense of invulnerability, parental/community restrictions, lifestyle etc.), over which the service may have relatively little control. There is no real evidence that low rates of utilization are simply due to lack of consultation with adolescents or that adolescents clearly know what they want, although individuals/organizations working

with adolescents firmly believe that consultation should take place.

Many international organizations support a focus on reproductive health of girls/young women because they bear the immediate consequences of unwanted and unsafe sexual behaviour to a larger extent than boys/young men do. Yet it is increasingly acknowledged that sexual norms will not change if they remain as marginal to these programmes as they do now. At present boys/young men are largely reached through:

1. NGOs working with difficult to reach sub-groups, such as children and adolescents on the street, i.e. those who are already alienated from the system (WHO, 2000c)
2. STI/HIV prevention programmes targeting young people at high risk, such as army recruits, truck drivers and young men in police detention i.e. those under strong peer pressure to exhibit “appropriate male” behaviours
3. community based condom distribution programmes, i.e. through (random) encounters on the street
4. the private sector, including private doctors, pharmacists and vendors, i.e. through services which, in many countries, are difficult to regulate and may not provide correct advice or treatment.

On current evidence it is difficult to know how to provide young men, or for others not utilising available services, with a wider range of health services of good quality. This indicates a need for more population-based studies of health-seeking behaviour as well as models for predicting demand for different aspects of an adolescent service.

6: There are a number of approaches for increasing service utilization by adolescents (in places where a user friendly health services exists)

EVIDENCE:

There are several potential strategies to increase service utilization.

- **Linking schools to health facilities**

Linking schools and clinics is often recommended as a way to facilitate referrals. In countries where this has been tried it has usually involved health workers going into nearby schools to provide education on sexuality, substance use and information on services provided at the health facility. If a large proportion of adolescents attend school, there is potential to reach a large audience, using this approach (WHO, 1998b). This strategy is being evaluated as part of an intervention strategy in Mwanza, Tanzania (WHO, 2000d).

- **Community mobilization**

There is preliminary evidence from studies in Zambia (WHO, 2000d) that adolescents are more likely to utilize reproductive health services in communities that are more accepting of such services. Consulting and involving parents and other community 'influentials' may foster an environment which legitimizes the adolescent's right to access sexual and reproductive health services. These findings are in line with a body of research, conducted largely in the US, which emphasizes the importance of family and socializing processes that promote health (Elliot, 1993). The contrary view is that in some communities, trying to involve the community may result in a hardening of attitudes. It is suggested that, when involved in activities such as condom and contraceptive provision to unmarried adolescents, it might be better to do so silently. This may enable ambivalent community members to turn a blind eye to this work.

- **Telephone help-lines and radio phone-ins.**

Interventions such as telephone lines can help adolescents to identify service sites. These have been tried in many countries and are usually very popular with young people, especially boys/young men. TARSHI (Talking About Reproductive and Sexual Health Issues), a help-line in New Delhi, India has found that 80% of callers are men and one third call more than once, mainly for information on contraception, HIV/AIDS and sexual concerns such as masturbation, body image, sexual urges and relationship problems (Chandiramani, no date). The service, like many others, has no means of checking whether referrals to appropriate agencies are successful. A doubling in attendance at a local health facility was reported in response to one radio programme in Uganda (Senderowitz, 1999) but no increase was seen in Thailand (Poonkhum, personal communication), where it appeared that anonymity, rather than face-to-face consultation, was the attraction of the phone-line. The long-term financial sustainability of such projects is always in question.

The mass media could play a role in shaping opinions and norms but widespread coverage requires considerable investment. Soul City (South Africa) is an example of an organization which has prime-time slots, including a weekly popular television drama, a radio drama programme broadcast daily in nine different language stations and ten community radio stations, printed materials, educational packages and publicity, advertising and advocacy. Themes are varied but have included adolescent sexuality and violence against women. Ongoing evaluation is an integral part of the Soul City initiative. Carefully thought through studies are to be undertaken in the UK to assess the national media campaign to reduce teenage

adolescent pregnancy (Social Exclusion Unit, 1999).

- **Peer promoters**

Peer programmes train young people to take health messages or health products to other young people of similar age and background. Peer programmes have come to be a hallmark of an adolescent service (Senderowitz, 2000). One of their main advantages is that the cultural similarity of promoters to the target group helps ensure that the language and messages used are relevant and appropriate. Feedback from peer promoters is taken as evidence that the target population is being consulted and involved. There have been many programmes and many evaluations, although most of these are unpublished reports from organizations running peer programmes. Three main benefits have been identified: i) the peer promoters benefit themselves from being involved, ii) peer education fosters short-term individual behaviour change; long term evaluations are not available, and iii) peer programmes stimulate a demand for services, perhaps through enhancing linkages to parents, families and communities (WHO, 2000d).

A post-intervention survey of the West African Youth Initiative in Nigeria and Ghana (18 months later) showed increases in knowledge and in the use of modern contraceptive methods compared to baseline (Lane, 1997). More adolescents in the experimental than in a control group reported taking protective measures against STIs/HIV. Similar results were obtained from a CARE project in Kenya (Chege et al, 1995) and elsewhere. In most of these unpublished reports the main outcome indicators have been knowledge on STI/HIV and condom/contraceptive use. Much of the reporting would be difficult to verify.

On the down side, the proportion of adolescents reached by peer promoters may not be high. In one urban project in Zimbabwe, exit interviews at health facilities showed that only 10% of young people interviewed had met

with a peer educator in the community, but those contacted did seem to be at higher risk (WHO, 2000d). Other problems include high turnover and payment for services (FOCUS, 1997), and of sustainability. Peer promoters need to be recruited, trained and supervised, and new ones need to be brought on board to replace the ones who leave.

These problems have also been experienced by other peer education programmes – notably those among female sex workers to prevent STD/HIV – and are relevant when considering how much effort to put into this activity. In Kenya and Zimbabwe (Ngugi et al, 1996), a female sex worker peer programme apparently led to increased condom use and safer sex practices, as well as declines in STI/HIV, although in practice it was impossible to separate out the contribution of the peer programme from other programme elements (e.g. improved STI management). This project, like most others, has been successful as a relatively small demonstration project, undertaken by dedicated persons and organizations. Larger scale programmes would need considerable planning, management and human resources.

IMPLICATIONS:

At present there is only limited evidence that the above approaches increase service utilization, although they may make other contributions to an overall programme for adolescents. Media approaches may be very successful in promoting knowledge – especially among boys/young men – but to relate this to service uptake would be difficult. Peer approaches may be invaluable in involving young people, giving a sense of ownership and thereby promoting the personal development and confidence of those involved. The involvement of adolescents in planning, implementing and monitoring adolescent friendly services is viewed by some as an essential element of an adolescent friendly service. However, whether it is feasible and cost-effective to do this on a large scale requires further research (Mehta, personal communication).

7: To complement and extend coverage of government-run health facilities for adolescents, other channels could be made available. Adolescents are much more likely to obtain the services if existing resources are networked

EVIDENCE:

Government-run health services have the advantage of being able to offer large-scale coverage and continuity. Many aspects of a quality adolescent service are not controversial and governments have a responsibility to make appropriate health care available to all individuals. There are other sources of health information and services that lie outside the public sector which are often not well known to adolescents. If the organizations and individuals concerned work together, this would expand the range of services available and provide referral opportunities. This is desirable because adolescents are a diverse population and the issues of importance to them cannot be addressed through only one channel. This is why adolescent friendly services have to build closer relationships with other parts of the health system, as well as with programmes offering other services, such as basic literacy and numeracy, education, employment training, job counselling and housing (Epstein, personal communication).

- **NGOs**

Family planning NGOs have often been at the forefront in delivering reproductive health services to adolescents and have been instrumental in contributing to the development of national level policies (Senderowitz, 2000). Some of the large NGOs are well funded and technically strong. Many took their programmes for young people forward, first through Youth Centres and, more recently, through teams of youth promoters involved in outreach work to increase contraceptive and condom utilization among those less likely to use services (WHO, 2000d).

Other NGOs working with children and adolescents address different issues. Some are guided by an empowerment approach and offer some of the development schemes that complement improved health – such as literacy programmes, vocational training programmes and income

generation programmes. Some reach out to those with special needs, such as those who are homeless, or those with AIDS or substance-use related problems. Many of these organizations would not describe themselves as specifically health-oriented, yet most are involved in health education, and often provide first-aid and treatment of common illnesses because their client groups are very reluctant to go to regular health facilities. NGOs working with children and adolescents on the street see the value of i) avoiding duplication of services, ii) improving their relationships with other health service providers, and iii) publicizing the services available (WHO, 2000c). The existence of an adolescent friendly health facility to which they can refer would seem to be attractive to many NGOs.

- **The private sector**

In a growing number of countries private hospitals, clinics and pharmacies are taking on an increasingly important role in the provision of health services. They may be willing and able to fill gaps in the services available, but presently it is difficult for health workers to identify private sector providers to whom it might be appropriate to refer adolescents. In many countries in Europe, pharmacists have been mobilized (and have been trained) to provide information to adolescents and other population segments, to issue emergency contraception, to experiment with one-stop sexual health consultations and to refer young people to appropriate service-providers. There are similar initiatives under way in some African, Asian and Latin American countries as well. Private sector providers will be preferred by some young people – especially those seeking anonymity and a quick service. A study in Thailand revealed that men who went to pharmacies for STI treatments were younger, had less education and income, and engaged in riskier sexual practices than men seen in private or government clinics

(Benjarattanaporn, 1997). Those attending specialized private STI clinics (and who were presumably better-off) got the most comprehensive services. Clearly more studies are needed to explore the role of this widely available resource, in other settings.

- **Social marketing programmes**

These programmes make condoms, over-the-counter contraceptives and some other products available at places where adolescents congregate, at prices they can afford. These initiatives are also backed up with strong promotional efforts, drawing upon commercial advertising approaches. There is growing experience in social marketing programmes deliberately targeting adolescents. Some projects have been exciting and innovative. The Tsa Banana project, a USAID-funded project. (Population Services International, 2000; Harris, no date) aimed at improving adolescent reproductive health in Lobatse, Botswana by branding and promoting sources of reproductive health services – clinics, shops and games rooms which provided information and advice. The project team also ran promotional shows and visited schools. At the end of the eight month project 68% of female and 71% of male adolescents had heard of the Tsa Banana project. Belief about AIDS and preventive knowledge appeared to have improved but uptake of condoms was not improved, nor did the females' view change that male partners would lose their respect for them if they initiated condom use.

Most social marketing programmes focus on knowledge and contraception/condom use and at present only address one aspect of adolescent health needs. As with peer promoters, sustainability is a serious issue, and again would probably be best

addressed by utilizing different approaches to achieve defined objectives, as part of an overall strategy.

IMPLICATIONS:

Networking resources and services will provide the best chance of reaching many more adolescents with both general and specialized services. The rationale for this needs to be widely shared so that the range of available services can be identified and referral systems developed (between health facilities and other organizations, and between different levels in health systems). It could also lead to a reduction in duplication and to the establishment of services that are currently not available.

There is a real need for more cross-referral, joint planning and complementary delivery of information, counselling and services among organizations. This requires mutually agreeable service standards and less competition between NGOs reliant on external funding sources. It has been suggested that governments and donors that support reproductive health services should consider funding “consortia” of private and public, rather than individual, organizations (Epstein, personal communication).

Providing services for adolescents is more difficult than for children, for whom there are packages of interventions, such as the Integrated Management of Childhood Illness, which, if implemented on a large scale, rapidly reduce morbidity and mortality rates from common infectious diseases and nutritional disorders. The situation is far more complex in adolescence and there has been less progress in defining programme elements which can be scaled up and will have rapid, measurable outcomes beyond improved knowledge and condom use.

8: It would be helpful to define the elements of a core package of health services and how it could be developed and provided in different settings/contexts

EVIDENCE:

The idea of a core package is to define a set of services that would be available to adolescents in the primary care setting. At the American regional consultation on Adolescent Friendly Health Services (WHO, 2000e) the core package at primary care level was defined as follows:

- monitoring growth and development
- assessment/detection/management of problems and problem-behaviours and referral to other service providers when they cannot be handled at primary level
- information provision (and counselling) on issues such as bodily changes, personal care and help/care seeking
- immunization.

At the African consultation (WHO, 2000d), the package of preventive and curative services proposed was as follows:

- General health (tuberculosis, malaria, endemic diseases, injuries, accidents, dental care)
- Reproductive health (contraceptives and condoms, STI treatment, pregnancy care, post abortion management)
- Voluntary confidential counselling and testing (VCCT) for HIV
- Management of sexual violence
- Mental health services, including for substance use
- Information provision and counselling on development during adolescence, sexual and reproductive health, nutrition, hygiene, substance use (tobacco, alcohol and other psychoactive substances).

The “Essential Services Package” which is to be implemented in South Africa differs in several respects (WHO, 2000d). This programme will have established adolescent health care services at primary care level throughout South Africa by the end of 2001. A randomized-controlled trial is planned to

evaluate the impact of the intervention on STIs, HIV, unwanted pregnancy and adolescent health-seeking behaviour.

Its components are:

- Information and education on sexual and reproductive health
- Information, counselling and referral for violence/abuse and mental health problems
- Contraceptive information and counselling and provision of methods, including oral contraceptives, emergency contraception, injectables and condoms
- Pregnancy testing and counselling, ante-natal and postnatal care
- Pregnancy counselling and referral
- STI information, diagnosis and syndromic management of STIs
- HIV information, counselling and appropriate referral if voluntary testing and counselling is not available.

The South African package has a reproductive health focus – HIV, STIs, pregnancy and violence, which is often sexual in nature. The package has been developed in a country where termination of pregnancy is legal. It assumes availability at primary care level of the capacity to provide counselling services, a range of contraceptive supplies, pregnancy tests and HIV testing kits in some cases. Voluntary counselling and testing is thought to be a service in which adolescents are interested. The evidence for this is observational (Horizons project in Kenya and Uganda, reported in Senderowitz, 2000), as is the evidence that there is strong positive behavioural change amongst young people who have been tested. The package incorporates antenatal and post-natal care, although these functions are usually extended to adolescents as part of routine pregnancy care (presumably with the intention of improving on current practice). It is an example of a country bringing a basic package in line with its priorities, legal framework and available resources.

IMPLICATIONS:

It is clear from the above examples that a core package cannot be a “fixed menu”. Individual countries have different economic constraints which will be reflected in what is included. This is why it will be important to have a clearer sense of the cost effectiveness of different interventions and combinations of services. Experience has shown that integrated family planning and sexual health services do not reach the groups at highest risk of STI/HIV (Dehne, personal communication), and this confirms the need for a range of networked services. What is also 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. The first packages

would reflect the assumptions outlined in this document on what is likely to work on the basis of current understanding. A strong evidence-base for the effectiveness of different packages should be instigated through research. The underlying principle for any package would be that it could be made widely available (i.e. ability to go to scale is important), sustainable, of good quality and lead to outcomes which must be clearly specified. The South African trial will assess reproductive health outcomes; a similar trial might be established for a more general package of health benefits, and in settings where the infrastructure is less developed. It is important to clarify whether a trial is designed to test the effectiveness of the package under ideal conditions (usually the case in expensive trials) or under the conditions that are likely to prevail.

9: Health care providers require technical competence relevant to adolescent health and development

EVIDENCE:

- **Technical competence**

Some aspects of adolescent health and development are not taught at the undergraduate level in medical and nursing schools; additional training is required for many health professionals to enable them to respond to their adolescent clients/patients more effectively and with greater sensitivity. Areas in which competency-based training is required include communication skills (for information provision and counselling) and clinical skills related to diagnosis and treatment for problems that affect adolescents (including those that often go untreated, such as menstrual disorders, or physical/sexual abuse). Assessment and management guidelines (including standard operating procedures) have been drawn up for a number of adolescent conditions and are used in some places (Elster & Kuznets, 1992).

to show adolescents respect, and to be able to engage them and to win their confidence and trust. Some key attributes can be taught (such as listening skills), but some people naturally relate well to adolescents and will perform better in this role.

Health services traditionally have concentrated on women and the majority of nurses are female. It has been argued that young men benefit when there is a male health professional to whom they can talk/question about their sexual development or sexual performance as these issues cannot easily be discussed with anyone else - especially peers (Laack et al., 1997).

- **Specialized referral care**

Although 'adolescent medicine' is a speciality in some countries, in many others the specialist to whom an adolescent will be referred will depend on the clinical problem at hand – growth problems may be referred to an endocrinologist, female reproductive problems to a gynaecologist and nutritional problems to a nutritionist (and sometimes

- **Interpersonal relations**

Good interpersonal relations should be the hallmark of an adolescent friendly service. Health care providers would be expected

to a psychologist). This is one reason for the urgent need for more systematic teaching on adolescent health and development issues - both at the undergraduate and at the postgraduate levels, and for well coordinated tertiary level services (Pasqualini, personal communication). A similar issue arises when adolescents are treated in disease specific programmes – including those for infectious diseases such as tuberculosis and those for chronic conditions such as asthma. These programmes should be encouraged to consider whether - and if so how and why - adolescents need to be managed differently from children on the one hand and adults on the other.

IMPLICATIONS:

International agencies can legitimize support for quality services through implementation of international consensus statements, use of standard clinical

10: Quality assurance/improvement methods, which empower health care providers to deliver client-centred care, should be applied to health services for adolescents

EVIDENCE:

Quality assurance is a set of activities to measure, monitor and improve care over time so that the service is as safe as possible (Silimperi, personal communication). Accountability and clinical governance have become matters of public and political concern.

Dimensions of quality, which are considered important for all services, are "technical competence, access to service, effectiveness, interpersonal relations, efficiency, continuity, safety and amenities" (Brown et al, 1998). It is considered important to focus not only on the qualities required, but also on the processes that bring about - and maintain - improvements in reproductive services (Blake et al., 1999).

In relation to adolescent friendly reproductive health services, two dimensions of quality considered to be important are "access" (determining whether an interested young person "reaches the door" of a health facility) and "service quality" (the attractiveness and

management guidelines and provision of support for capacity building, and general insistence on competence.

Training in adolescent health should move forward through both i) in-service training and ii) improving nursing and medical curricula - for pre-service training. All health workers should have a basic understanding of adolescent health but it takes more than this to work well with adolescents. The selection of staff, and the criteria for their selection, should be carefully considered, as should be mechanisms to provide ongoing support to staff who have been trained and are working with/serving adolescents.

Building the capacity of health workers is only one aspect of developing an adolescent service. The infrastructure of the service must also support their work, as must the legal framework within which they operate.

benefits of the treatment that clients receive once they are "inside the door") (Nelson et al., 2000).

A critical operational issue in quality assurance is the development of standards. In general, a standard represents a desired level of health care; standard setting needs to be done in relation to each of the dimensions of quality noted above (technical competence, etc.). Standards have to be explicit, known by all, set by a competent authority, on an organizational level. Accreditation programmes are under way in several countries. These programmes use a three-pronged approach: firstly defining standards, secondly assessing whether health facilities meet the required standards, and thirdly accrediting those which do meet the required standards, and assisting those which do not, to take remedial/ameliorative actions.

All the dimensions of quality noted above apply to adolescents and to other population segments. A health facility which provides adolescent friendly services would certainly need to include several of the 'general' elements

of quality and, in addition, would want to be able to include several other elements of quality that are 'unique' to adolescents (e.g. in relation to technical competence, whether health workers are knowledgeable about specific issues in contraceptive provision to adolescents; in relation to accessibility whether adolescents of both sexes, in a given catchment area, are aware of an available service, and had used it if they needed to).

IMPLICATIONS

As the elements of adolescent friendly health services become established on the basis of future research and assessment, it will become imperative to develop standards for adolescent friendly services, using advocacy to press for their implementation. Operational procedures for assessing and improving the quality of the delivery of packages of services, within the economic framework of the country involved will assure this. More attention to outcome indicators, both clinical and at the systems level, will be necessary and will require better data collection and health information systems. Within the context of adolescent services, monitoring the quality of interactions between service providers and clients will be challenging.

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V. LIST OF PARTICIPANTS AT THE GLOBAL CONSULTATION.

1. Representatives of organizations providing adolescent friendly health services in selected developing countries

Dr Halida Hanum Akhter, Bangladesh
 Dr Fernando Beltrán, Mexico
 Dr Ma. Divina A. Capuchino, Philippines
 Dr Buket Cinemre, Turkey
 Dr Uwemedimo Uko Esiet, Nigeria
 Dr Nada Haffadh, Bahrain
 Dr Aïda Ismail, Tunisia
 Ms Helle Karro, Estonia
 Ms Mwape Lubilo, Zambia
 Dr Rajesh Mehta, India
 Dr Winnie Moleko, South Africa
 Ms Irene Moyo, Zimbabwe
 Ms Edith Ronah Mukiiisa, Uganda
 Dr Ketu Nemsadze, Georgia
 Ms Banzragch Oyun, Mongolia
 Dr Diana Pasqualini, Argentina
 Ms Yupa Poonkhum, Thailand
 Dr Julieta Rodriguez-Rojas, Costa Rica
 Dr Maria Helena Ruzany, Brazil
 Dr Saidatul Norbaya bt. Buang, Malaysia
 Ms Teresita Silva, Philippines

2. Representatives of selected bilateral agencies involved in supporting the provision of health services to adolescents in developing countries

Ms Shanti Conly, United States Agency for International Development
 Dr Minou Fuglesang, Swedish International Development Cooperation Agency
 Ms Annette Gabriel, Deutsche Gesellschaft für Technische Zusammenarbeit (GTZ)
 Ms Anna Runeborg, Swedish International Development Cooperation Agency
 Ms Jeeva Saraswati Canadian International Development Agency

3. Representatives of selected international NGOs involved in supporting the provision of health services to adolescents

Ms Audrey Elster, African Youth Alliance
 Ms Sharon Epstein, Focus on Young Adults
 Dr Pamela Lynam, Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO)
 Dr Ann McCauley, Population Council
 Dr Manisha Mehta, Engender Health
 Ms Siobhan Peattie, Save the Children Fund, United Kingdom
 Ms Christina Rogala, Riksförbundet for Sexuell Upplysning (RFSU)
 Dr Pramilla Senanayake, International Planned Parenthood Federation
 Dr Cindy Waszak, Family Health International

4. Representatives of UN agencies involved in adolescent health and development work

Dr Nieves Andino, UNFPA
 Dr Marilen J. Danguilan, UNICEF
 Dr Bruce Dick, UNICEF
 Dr Laura Laski, UNFPA
 Ms Uyen Luong, UNFPA Representative
 Mr M. Mahalingam, UNAIDS
 Ms A. Mendoza, UNAIDS

5. Resource persons

Dr Loretta Brabin
 Dr John Howard
 Dr John W. Townsend

6. Secretariat

WHO Headquarters

Family and Community Health
 Dr Tomris Turmen

Child and Adolescent Health and Development
 Dr Hans Troedsson
 Ms Jane Ferguson
 Dr V. Chandra-Mouli
 Dr Adepeju Olukoya

Reproductive Health and Research
 Dr Shireen Jejeebhoy

HIV/AIDS
 Dr Vincent Habiyambere

Organization of Health Services Delivery
 Dr Naeema Al-Gasseer

Health Promotion/Non Communicable Disease Prevention and Surveillance
Mr Jack Jones

Mental Health and Substance Dependence
Dr Myron Belfer

WHO Office, UNICEF Geneva
Dr Abdel Al Abassi

WHO regional offices

African regional office
Dr Arabang Maruping
Mrs Adjoa Amana

American regional office
Dr Matilde Maddaleno
Dr Sandra Land

Eastern Mediterranean regional office
Dr Ghada Hafez

European regional office
Dr Erio Ziglio

South East Asia regional office
Dr Jorge Luna

Western Pacific regional office
Ms Sharifah Tahir

Department of Child and Adolescent Health and Development
World Health Organization
20 Avenue Appia, 1211 Geneva 27, Switzerland
Telephone + 41 22 791 2632
Facsimile + 41 22 791 4853
E mail cah@who.int
Web site <http://www.who.int/child-adolescent-health>