ACCELERATING ACTION FOR ADOLESCENT HEALTH IN THE EUROPEAN REGION

Two recent developments are of major importance for shaping the public health agenda in the European Region for years to come: primary health care (PHC) renewal (1) and the Tallinn Charter (2).

The Tallinn Charter outlines directions for health systems development in the WHO European Region if they are to efficiently contribute to health, wealth, and social well-being. The World Health Report 2008 makes the case for global PHC renewal, outlining the four sets of reforms that are needed to meet the expectations of citizens in the modern world: universal coverage, service delivery, public policy and leadership. The two documents share similar values and principles, and describe similar approaches for achieving the improvements that are required. This paper analyses their implications for adolescent health programmes in the Region.

Universal coverage for young people's health

There are many challenges in the European Region that hinder progress towards universal coverage of young people with effective interventions. These include young people's financial vulnerability, cross-border mobility, patterns of exclusion because of a range of factors including sex and age, and the specific needs of marginalized and vulnerable groups. Concerning the financial vulnerability of young people, there are a number of countries where adolescents are not covered by health insurance schemes or specific budgetary allocations. In some countries where youth friendly health services (YFHS) have been developed, the services that are provided rely on time-limited project funds. For certain groups of young people, for example, those whose parents are working abroad and have left their children behind, relatively small expenditures would be catastrophic. In a number of countries, with the current financial crisis and the diminished employment opportunities for young people, the period is increasing between the end of their insurance status as a child, and the beginning of a career.

Cross-border mobility is increasing in the region. EU mechanisms for cross-border health care try to address the issue of patient mobility, but migrants from outside the EU, many of who are young people, continue to fall through the cracks. For example, in Luxembourg almost 40 % of young people are from other EU Member States, and more than 15% of young people in Spain were non-EU citizens (3).

Boys are generally much less likely to use health services, even if there are specific initiatives to reach adolescents. Age per se may be a factor of exclusion. Traditionally designed health systems were built to serve the needs of ill and disabled people, while adolescents are more in need of preventive oriented services. Sexual and reproductive health service delivery is particularly "age sensitive", with some societies limiting their provision to adolescents.

Marginalized groups of adolescents are frequently not reached by health services even where efforts are under way to make them "adolescent friendly". In the past, many countries of the Region made concerted efforts to bring everyone into the mainstream, with virtually no efforts to provide those few individuals and groups who were not part of the mainstream with health and social services.

However countries are moving forward. The Republic of Moldova recently included YFHS in the list of services covered through mandatory health insurance scheme. There are efforts to respond to the special needs of males, for example by setting aside dedicated clinic times as in Estonia, or to reach marginalized adolescents, such as injecting drug users, as in Tajikistan.

Reforming services to deliver for young people's health

Poor quality of services for young people remains a main challenge to be addressed in service delivery reforms. Low effectiveness, especially in select outdated models of school health services (SHS), is another one. The third challenge is the fact that with the waves of health systems reforms and the trends of a shift towards the needs of an increasingly ageing population, young people's needs tend to be overlooked and neglected.

Health systems that existed in the past were often biased towards detecting health problems and providing curative health services rather than addressing preventive measures. They also tended to be fragmented with specialists focusing on particular organ systems (e.g. in many countries, there were adolescent gynaecologists) rather than on the holistic needs of individuals. As a result of this, health services are often of poor quality both in the way in which they are provided, and in the way in which they meet the expectations of young people. In some countries systems to improve and maintain quality are weak or nonexistent, and there is no commitment to dealing with this. Involving users in the design of health service provision to ensure that it meets their needs is not yet a routine practice in many countries.

The health system reforms provide an opportunity to reorient health service delivery systems to respond to the needs of adolescents. However, in many places, these reforms tend to be blind to the needs of adolescents. For instance, the recent transition to family medicine in many countries of the Region did not take into account that adolescents are as much members of a family as children and the elderly. Consequently, professional capabilities of PHC providers to deal with specific needs of adolescents are extremely limited, and the "age appropriateness" of PHC services is very low. SHS – a particular type of PHC services - have fallen between the cracks in health systems reforms. They continue to abound with non-effective interventions, to focus

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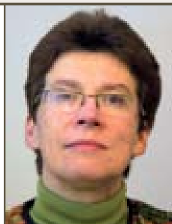

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on treatment rather than health promotion and are seen as less prestigious than other PHC professions.

However, progress is being made in many countries in the Region in trying to match services with needs. The United Kingdom is implementing the National Service Framework for Children, Young People and Maternity Services. Several countries – i.e. the Republic of Moldova and Kyrgyzstan - are making efforts in setting nationally agreed quality standards for YFHS so that any facility may be "measured" against them. Denmark, Belgium, United Kingdom and Croatia are just some of the countries that have reoriented SHS from a medical care paradigm to a social care paradigm over the last decades. The Republic of Moldova, Ukraine and Albania also recently embarked on this process.

Public policy reforms

The "health in all policies" call of the renewed PHC acknowledges the importance to address socio-economic determinants of health, as does the Tallinn Charter. In many countries, sectors other than health do not make the needed important contributions, or do so but their activities are not well coordinated.

Per se, "health in all policies" will not address the specific needs of young people unless there is a "young people's health in all policies" standpoint. The creation of opportunities for girls to study or work as a means of reducing early pregnancies, the decriminalization of needle and syringe exchange programmes, actions to reduce road injuries and violence due to alcohol use, and actions to protect young people against aggressive marketing of the tobacco industry are just some of the examples where the fact that a person is young requires tailored interventions. Multi-sectorial interventions should also address the issues of health care seeking behavior.

Leadership reforms

National level leaders in many countries are not committed to meeting the needs and fulfilling the rights of adolescents. Often support for actions in health facilities and communities is completely missing at the sub national level. Although evidence about decision making in public health are inconclusive, some from the European context revealed that setting priorities is consistently related to population health status, epidemiological data, burden of disease and, often, scope for prevention (4). Economic argument is increasingly appealing. As adolescents are often a relatively healthy segment of the population, reliance on epidemiological data of disease incidence and prevalence for priority settings becomes less relevant. Rather, the scope for prevention, economic argument, ethical and human rights considerations should be used in obtaining buy-in from leaders of various sectors.

In the framework of the implementation of the European strategy for child and adolescent health and development (2005), 12 countries started the development of their national strategies. While a positive sign of leaders' increasing awareness and commitment to adolescent health needs, there is a risk that these strategies will not be implemented unless concerted efforts are made to translate the actions proposed into existing work plans and budgets.

Conclusion

The adolescent health programmes, by the nature of their beneficiaries' needs, are consistent with the PHC renewed approach and the Tallinn charter. They advocate for, and make concrete actions in, ensuring universal coverage, reforming services to make them youth-friendly and make them part of overall health systems reforms. They advocate for public policy reforms along the "young people's health in all policies" paradigm. Finally, they advocate that leaders from all sectors consider the youth dimension in their policies. In these aspects, adolescent health programmes provide a very useful practical application of the PHC renewed approach and the Tallinn charter – documents that are merely political and directions' setting – and might be a litmus test for their implementation. On the other hand, adolescent health programmes should use the opportunity of both the PHC approach and Tallinn charter to accelerate the energy for their implementation.

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References

1. *The World Health Report 2008. Primary Health Care – Now More than Ever.* Geneva: WHO, 2008. http://www.who.int/whr/2008/en/
2. WHO European Ministerial Conference on Health Systems "*Health Systems, Health and Wealth*", Tallinn, Estonia 25–27 June 2008. Report. Copenhagen: WHO, 2009. http://www.euro.who.int/InformationSources/Publications/Catalogue/20090122_1
3. EU Youth Report. EC, Brussels, 2009
4. Allin S, Mossialos E, McKee M et al. *Making decisions on public health: a review of eight countries*. WHO, 2004 on behalf of the European Observatory on Health Systems and Policies.