Module 3: Evidence based approaches to health service provision to adolescents - Adolescent health and development with a particular focus on sexual and reproductive health - Assignment

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Health service provision to adolescents in Italy

Health services that contribute to the health and development of adolescents are intended to provide a clinical service, which often includes the provision of information, advice and counselling aimed at preventing health problems, or detecting and treating them.

Health services could be established at various levels: schools, hospitals, counselling centres, private clinics, community recovery, youth centres, educational institutions, work places, pharmacies...

In my opinion, it is not important where it is established, but it is important the large scale accessibility and knowledge of the service. The other important thing is the personnel of the health service: the consultant should be a health worker (medical doctor, midwife or nurse) well-skilled and well-trained, who can speak with adolescent, can understand them, non judgemental, and who can screen the problems and refer to the appropriate specialist or service (gynaecologist, psychologist/psychiatrist, social worker, paediatrician, community recovery...)

In Italy, there are no specific adolescent-health-services, but there are many kinds of health services accessible to adolescents. The first that comes into my mind is the "Counselling Centre" which is a public gynaecologic and antenatal clinic, present in almost every area, where often adolescent girls go when they start their sexual life, asking for emergency contraception, for contraceptive pill, or in case of positive pregnancy test; another easy accessible health service where often adolescent go is the gynaecologic emergency room in hospital for problems like emergency contraception, positive pregnancy test, problems during pregnancy, sexually transmitted infections…

Adolescents under 18 years old also refer to their paediatrician for any other kind of health problems (chronic or acute diseases).

In Italy, there are Community Recovery services for people (adults or adolescents) who have drug addiction, where they can live and work even for years, until they have completely been recovered.

There are also many kinds of Helping-Telephone-lines that can be called if someone (adolescent, adult or kid) has been raped, molested, beaten by a family member or abused.

During school time, the main health service consists of the Vaccine Programme, which is public, compulsory and is established by the Ministry of Health. During school there are also some preventive campaigns such us the HIV prevention, the HPV prevention, sexual education, drug prevention or road accident prevention.

Concluding, I think that in Italy adolescents can benefit of many kind of health services, specific for almost any kind of problem, but there's no an unique adolescent-health-service where every

adolescents pass by and the problems can be screened. So, sometimes, the problems remain ignored, or the information are not properly given.

The WHO's approach

The described WHO's approach to improving the quality and expanding the coverage of health services to adolescents is well structured and seems to be feasible. I think that the starting point is the National Level, developing national policies and ensure their application, and developing guidelines, operational procedures and training materials for health facility staff. I think that the most accessible place for an adolescent health service is the school and the users can then be sent to clinics, hospitals, or specialists when needed.

The Community members should be aware of the health service needs of different groups of adolescents, support their provision and address people to the health service. The health service should be thought as a first level assistance and not pretend to solve any kind of problem but just screen them. The starting point is the easy accessibility for everybody.

The National Adolescent-Friendly Clinic Initiative in South Africa

The National Adolescent-Friendly Clinic Initiative (NAFCI) is the adolescent health service programme started in South Africa in 2000 with the selection of 10 pilot clinics followed, in 2005, by 350 clinics participating in the programme.

The driving force of the programme is a team (youth–clinic staff–community) working together to achieve the goal, which is responding to the needs of South African youth in order to decrease HIV, teenage pregnancy and STIs.

The background of this programme developed in South Africa is particular, and cannot be compared with the one in other parts of the world. Africa is experiencing a youth health crisis: an estimated 40 million people were living with HIV at the end of 2005 and a projected 7000 young people become infected with HIV every day. About half of the people who acquire HIV become infected before they turn 25 and typically die of acquired immunodeficiency syndrome (AIDS) before they reach 35 years of age. Young women (less than 25 years of age) in developing countries make up about half of all people currently infected with HIV. For the majority of young South Africans, sexual activity starts in the mid-teens, with an estimated national average age of first intercourse at 15 years for girls and 14 for boys. Sixty-six percent of young women reported that the pregnancy was unwanted. In addition, adolescents' knowledge of sexuality and reproductive health is generally poor, and a substantial number have indicated a need for more information on such issues as pregnancy, relationships and sexually transmitted infections (STIs).

The NAFCI programme identified public health clinics as a vehicle for providing services to deal with the HIV epidemic.

Measuring the success of the programme was of critical importance. The first objective of NAFCI was to make health services accessible and acceptable to adolescents. Consequently, use of services was identified as a key indicator. In addition to use of services, it was felt that youth

attendance in the chill room was important. Chill room attendance reflected the young people's comfort in coming to the clinic for activities that promoted healthy lifestyles. Indicators were established to measure the success of the programme including:

- Number of adolescents using the clinic, according to age.
- Number of new adolescent clients using the chill room.
- Number of repeat adolescent clients using the chill room.
- Number of clinics that have received accreditation.

Clinic statistics forms were revised to include the age breakdown for young people.

I think that the NAFCI model is very well structured, the problem is that the programmes risk being unsustainable. For this reason, the collaboration with the Department of Health is critical to the institutionalization of the Programme.

A point that is not mentioned by the NAFCI programme is disease prevention, not only in terms of STIs, but also considering smoking, drug addiction, road accident, cardiovascular disease, dysmetabolic disease, cervical cancer prevention... Even if most of these problems are not limited to adolescents, they can be prevented starting from adolescent age so it is important to learn as soon as possible the risky consequences of a wrong life style, and starting as soon as possible preventing them.

Another important note in my opinion is introducing the cervical cancer screening in the context of the adolescent-health-clinic because of the early age of the sexual life beginning in this country.

Assignment documents

1. WHO. Adolescent friendly health services - An agenda for change. Geneva: WHO; 2002.
2. WHO. Evolution of the national adolescent-friendly clinic initiative in South Africa. Geneva: WHO; 2009.
3. WHO. Methods and tools to scale up quality health service provision to adolescents. Geneva: WHO; 2010.