



**Best Practice in Delivering Sexual and
Reproductive Health Services to Young People in
Victoria
A Review of the Literature**



**Geraldine McDonald
Jennie Mullins
October 2002**

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Acknowledgments

Family Planning Victoria and the Young People's Sexual and Reproductive Health Redevelopment Project workers, Geraldine McDonald and Jennie Mullins would like to acknowledge the following individuals and organisations for their invaluable support of and input into this project:

The Advisory Committee to the Young People's Redevelopment Project:

**Craig Hodges, Centre For Adolescent Health, CAH
Dave Hamra and Denise Francisco, City of Melbourne
Janet Jukes, Youth Affairs Council of Victoria, YACVIC
Philomena Horsley, Australian Research Centre for Sex, Health and Society,
FPV Staff: Lynne Jordan, Dr Kirsty McNabb, Fiona Beale, Lea Trafford, Ian Seal, Dr Hennie Williams
FPV Board: Christina Lawrence
Administrative support Judy Roberts**

We also wish to acknowledge:

- **FPV staff. Special thanks to Jill Aron and Kordula Dunscombe**
- **Nell Blythe, Frontyard**
- **Dot Henning, Young People's Health Service, CAH**
- **Kit Fairley, Melbourne Sexual Health Centre.**
- **Therese Willems and youth consultants, Cara Williams, Michelle Powell and Joanne Ibrahim with the Youth Access Project, Moonee Valley Melbourne Primary Care Partnership. DHS**
- **National Division of General Practitioners**
- **Royal Women's Hospital**
- **Inner South Community Health Centre**
- **YSAS**
- **Christina Lawrence and Nicki McFarlane**



Introduction

Background to the Young People's Services Redevelopment Project

By way of this project, Family Planning Victoria (FPV) has undertaken a review of its services to young people, beginning with refining the definition of the young people it serves, examining how to best reach those young people most at risk in our communities, identifying the best strategies and interventions based on the available evidence and by listening to the voices of the consumers. With a well demonstrated expertise in delivering services to young people, FPV and the AC are now well-placed to examine their direction in providing services to young people, how programs will be targeted and what models lead to more effective practice and programs of best bets.

One of the driver's behind this project is the current property lease for the Action Centre (AC), Family Planning Victoria's (FPV) dedicated young people's sexual and reproductive health service in the Central Business District of Melbourne, is due to expire in December, 2002. The expiration of the lease would seem an ideal opportunity for FPV to evaluate service delivery to adolescents across the clinical and education streams. Whether to relocate, co-locate or expand the Action Centre needs to fit within the FPV mission and vision statements and reflect the organisation's focus on servicing those people who are most "at risk" in the community or have difficulty accessing mainstream services. (Cuneen, 2002)

History of the Action Centre

Since the early years of operation, Family Planning Victoria (FPV) recognized that the sexual and reproductive health issues facing young people in Victoria were not the same as those facing the original target group for whom services were designed, namely women needing advice regarding contraception and the spacing of pregnancies. FPV's creation of the Action Centre in the 1970's was in keeping with the Federal government policy of the day that: *"all people should have ready access to family planning advice."* (Mather, 1995 P. 62) In response to the barriers young people were facing in accessing services from General Practitioners and the generalist Family Planning Association (as it was then called) services, and despite the historic departure of the Whitlam government, a service specific for young people was opened in 1976 in the Central Business District of Melbourne. The Action Centre (AC) was established: *"to provide advice and counselling on a wide range of services –drugs, employment, relationships, recreation, with special contraceptive sessions to be just one of the services provided...It was anticipated that the AC's would cater for mainly young unmarried adolescents but that they would be open to all people-there being no barrier of either age or sex."* (Dunstan and Hain, 1977, cited in Mather, 1995 P. 62)

Serving Young Victorians

The mission of FPV is:

“to provide to Victorians a range of high quality sexual and reproductive health services based on current evidence, which are accessible, culturally appropriate and responsive to community needs and with particular emphasis on targeting those members of the community most at risk or marginalized.” (FPV Annual Report, 2000-2001) FPV serves young people via its open age sexual health clinic at FPV’s main site in Box Hill, an eastern suburb of Melbourne. S&R services are also delivered through the youth specific service at the AC in the Central Business District, and at various satellite clinics which are co-located with either youth or generalist health services. All clinics are staffed by General Practitioners and nurse/educators with expertise in adolescent health.

Education, Training and Support Services

FPV also has a comprehensive Education, Training and Support Services (ETSS) arm of the agency which deliver numerous services, both direct education for young people and professional training of those working with young people. Youth services can also be tailored to suit the particular needs of young people and can be delivered to rural and metropolitan areas. Direct Education programs include:

- Group education sessions for schools and tertiary students.
- Education sessions for community groups
- Disability education for groups, individuals, their families and carers e.g. sessions for clients with an intellectual disability.

The above education services are offered on a fee for service basis and are available both in the metropolitan and rural areas of Victoria. Health promotion activities are provided e.g. tertiary expos, community health expos, development of education resources in the sexual health area for the delivery of schools programs in the disability area. The FPV Library (and bookshop) serves as a useful place for accessing information by students and staff and a new website will make this access more readily available Victoria wide.

Disability Client Services

The Sexuality Education and Intervention Service (SEIS) is a statewide outreach sexual service for people with an intellectual disability who are at risk of being harmed or offending due to a lack of human relations knowledge. It offers counselling and support for people with a disability in the area of sexual and reproductive health and relationships. No fee is charged for these direct client services.

Professional Development

The training and education of health professionals are indirect services that benefit young people. Accredited courses to doctors and nurses include:

- Update seminars for doctors, nurses, community health workers
- Training Programs for staff working in schools/educational settings e.g. teachers, school welfare workers, school counsellors and secondary school nurses.
- Professional training for disability workers e.g. on how to implement a human relations program

- Tailored programs to suit the particular needs or issues relevant to a particular school or community
- Conference presentations
- Training of FPV sessional educators

Training courses for doctors and nurses, educators and allied health professionals in sexual and reproductive health also have a flow on benefit to young people when they access services from these health professionals. Effectively, the Education, Training and Support Services area provides both direct client and indirect services in the education and training of the Victorian community as well as the training of various health professional personnel. (Cuneen, 2002)

Action Centre

Many things remain the same since the creation of FPV's Action Centre. It is still called the Action Centre, it operates in the Central Business District of Melbourne, and it still offers a comprehensive range of health and wellness sexual and reproductive (S&R) services to young people between 13-25 years of age, adopting a social model of health with emphasis on health promotion. (FPV Annual Report, 2000-2001).

"A social view of health means that we must intervene to change those aspects of the environment which are promoting the ill-health, rather than continue to simply deal with the illness after it appears, or continue to exhort individuals to change their attitudes and lifestyles when in fact the environment in which they live and work gives them little choice or support for making such changes." (South Australian Health Commission, 1988, cited on NAAH website)

Young people, including rural youth, continue to receive services in a safe and confidential environment. Direct services include clinical, health education and counselling, while indirect services entail school and community based prevention, education and training of youth and health service providers, and community development activities. AC services to young people include:

- **Sexual and Reproductive Health Clinics** (many young people access the clinic for STI treatment including HIV or for contraception advice and contraceptives and wellness checks such as pap smears)
- **Health Promotion** sessions are available to young people such as secondary students which may address sexual and reproductive health, relationships, high-risk behaviours and sexual identity issues.
- **Counselling** via individual sessions or peer driven support groups for same sex attracted youth. Many young people request support in relation to sexual identity issues, depression, sexual assault, unintended pregnancy and a whole range of other issues such as unemployment, homelessness and substance abuse that one addresses within a social model of health.
- **Information, Referral and Networking** The AC offers a telephone information line which is accessed by a high proportion of young people from rural areas. The AC relies on its strong network of youth providers to assist its service users by effective referral. In addition the AC provides ongoing support to SOMAZONE the interactive Q&A website created by the Australian Drug Foundation which addresses all concerns of young people including sexual health
- **Outreach.** The AC currently provides services in two centrally located youth specific services, one session per week at Frontyard a collaboration and collocation of youth services serving at risk young people and at the YWCA

GirlStorey program, an arts based program for homeless young women. Two generalist satellite clinics also see young people; one operates out of a regional hospital in rural Victoria and the other from a community health centre in Melbourne.

- **Community Development.** The AC has initiated development of S&R health services in communities where need has been demonstrated, particularly with Gay and Lesbian young people.
- **Professional Development** is available to tertiary students and health professionals or those working in the youth sector.

Direct services are free to those young people under 18. However there is a \$5 per year charge for those between 19 - 25 years, who are students, or on benefits, or \$25 per year to those working full time. Education, training and support services are provided on a fee for service basis. Consistent with the early intent of the service, the AC continues to target those considered most at risk, while not refusing any young person a service. However, the AC does not seem to have the breadth of social and health service delivery originally envisioned. Essentially it provides comprehensive S&R health services within a social model of health in a stand alone sexual and reproductive health service.

FPV has a long history of service provision to young people and recognises the need for a diverse range of services, programs and activities to respond to the varying needs of young people. Despite the obvious success of the Action Centre in meeting its mission to serve the young people of Victoria for over 25 years, there are serious challenges facing Statewide service provision agencies such as FPV, in terms of the resources available specifically for S&R services to young people, resource allocation, effective approaches and coordinating with all levels of government and the non-government sector.

Defining Our Target Group

Defining the young people we serve is another challenge given the multifarious definitions and age ranges in operation between various sectors and reporting requirements. To further confuse matters, the term “adolescent” is often used interchangeably with the terms “youth”, “teenagers” and “young people”. In 1998, a common albeit nebulous definition of adolescence was adopted in a joint statement by the World Health Organization (WHO), the United Nations Children's Fund (UNICEF) and the United Nations Population Fund (UNFPA) *“as a distinct and important period in a person's life”* that *“refers to people between the ages of 10 and 19”*. (SIECUS, <http://www.siecus.org/pubs/cnct/cnct0000.html>)

In much of the literature “adolescence” is usually described in terms of a rite of passage or a transition from childhood to adulthood, which is closely related to pubertal changes taking place. *“The period between childhood and adulthood is a time of profound biological, social, and psychological changes accompanied by increased interest in sex.”* (Di Censo et al, 2002, p. 1427) Definitions reflect the frameworks used to explain adolescence. Within the developmental framework, adolescence is often either viewed from the biological standpoint as a time of “storm and stress”, or from a social construction model which views adolescence as an age staged process of negotiating social and cultural influences. (Milburn, 1995) Most definitions could be described as adultist and usually characterize adolescence as a time of emotional turbulence, rife with risks. (Op Cit) In reaction to the frequent onset of sexual activity and increased degree of risk taking during adolescence, it is usually a period that is problematised by social

researchers: *“Adolescence is a period of exploration and experimentation, but young people often lack the knowledge, experience and maturity to avoid the grave risks that confront them.”* (<http://www.inclen.org/research/ah.html>) Wyn however, proposes that we need to involve young people in new participatory research methodologies in order to lead to greater understanding and more accurate, non-adultist descriptions of the forces at play during adolescence. (Wyn, 2002)

Fuller (2002) described adolescence as a period where there is an: *“intertwining of idealism and risk taking.”* Many definitions acknowledge that these years encompass the process of: *“...the growth of the individual identity; extension of friendship, relationships and interests outside the family; and the progression towards emotional and financial independence.”* (ABS Australian Social Trends, 2002) In addition, in their interactions outside of the family environment young people seek and are exposed to risky behaviours such as substance abuse, illegal activities, and high-risk sexual activity. Even though people of all ages are exposed to such risk, the concern is that young people have the skills to reject or recover from such exposures and resist making them life long habits.

Adolescence is often referred to as a developmental process but it should not be viewed as single staged. The New South Wales Association for Adolescent Health defines adolescence as occurring between 12 and 25 years and as: *“a time of transition between childhood and adulthood. It may be defined as a period within the lifespan when most of the individual's biological, cognitive, psychological and social characteristics are changing.”* (NAAH website) They accept three development stages divided between early, middle and late adolescence for which there are specific tasks to be completed. Adopting a developmental view of adolescence assists service providers in developing more appropriate and responsive programs.

Many definitions appear oversimplified and fail to capture the complexity of viewing adolescence within a holistic, cultural and developmental, frequently non-linear, context. Furthermore, despite being a period of sexual and sexuality development, most definitions completely ignore this as an important part. This is affirmed by SIECUS who state that becoming a sexually healthy adult is a key developmental task of adolescence and achieving this requires the integration of psychological, physical, societal, cultural, educational, economic, and spiritual factors. (SIECUS, <http://www.siecus.org/policy/poli0002.html>)

In Australia, the first report on the health and wellbeing of young people, by the same name, described adolescence as *“the transition from childhood to adulthood is a gradual process, beginning and ending at different ages for different individuals.”* (Moon, 1999, P.3) It sets the age parameters for this period as between 15 to 19, but more broadly defines young people as between the ages of 12-24 years. The Centre for Adolescent Health, Victoria's peak adolescent health service however, has defined adolescence as between 12-18 years. (DHS, 2, 2000) Wyn believes that researchers may rely too heavily on no longer applicable *“concepts of age, categories, development, transitions and status,”* given that changes in young people's social context has new implications for the meaning of adolescence and adulthood. (Wyn, 2002, p.2)

The majority of young people negotiate these early years of adulthood successfully. (DHS, 1, 2000) Nevertheless, it is estimated that between 10-20 percent will undertake serious risky behaviours. (Op cit) Dryfoos, described the term “adolescents at risk” as “a

segment of the population that under current conditions has a low probability of growing into responsible adulthood". (Dryfoos, 1991, p.630) She emphasised that even though we talk about high risk behaviours, this in no way implies blame, as most of the factors are structural in nature, largely induced by socioeconomic factors, and are not of their own making. (Op Cit) Patton, Director for Centre for Adolescent Health in Victoria, maintains that it is not useful to categorise adolescents as "at risk" in that it hides the fact the all adolescents have health needs along a continuum. (Centre for Adolescent Health Conference 2002)

The Australian Medical Association President defined "at risk" adolescents to include: *"rural, unemployed, Aboriginal & TSI, Young People who experience family breakdown and Young People with mental health issues"* (Phelps, Centre for Adolescent Health Conference 2002) A working party established by the City of Melbourne in 2000 to review services provided to young people in central Melbourne, adopted the working definition of young people as those between 12 and 25. This same group adopted the criteria to define "at risk" young people to include:

- Homelessness or at risk of
- Family breakdown
- Early school leaving
- Abuse
- Suicide

In the context of sexual and reproductive health, young people are primarily at risk for unintended pregnancy, sexually transmitted diseases, including HIV/AIDS and other adverse effects to their wellbeing due to a lack of control over their sexual health. "At risk" in this definition would need to encompass several other co-occurring risk factors such as:

- High-risk sexual practices
- History of sexual assault- Adolescents who report prior sexual abuse engage in high risk sexual behaviours and are at an increased risk for adolescent pregnancy. (Raine et al, 1995.)
- Mental Health issues
- Lack of access to appropriate and accurate services
- Same sex attracted (Gay and Lesbian young people are over represented in suicide statistics, Wilder, 2002)
- Sex workers
- Substance abuse and IV users
- Limited access to primary care providers
- Member of disadvantaged community, low socio-economic status, culturally and linguistically diverse, Aboriginal and Torres Strait Islander, disabled, rural.

It becomes apparent that there is a certain arbitrariness in defining the parameters of adolescence depending on the data available and the purpose and framework for understanding adolescence. For the purposes of this report, and consistency in current Australian governmental definitions and service context, we will adopt the broader definition of young people to include people between 12 and 25 years of age.

Method

The Young People's Services Redevelopment Project adopted a three-pronged approach.

1. A review of the relevant literature of best practice models of sexual and reproductive health service delivery to young people, and an environmental scan of the public policy climate impacting on such service delivery.
2. An audit of Family Planning Victoria services delivered to young people in the previous twelve months including:
 - analysis of service utilisation data
 - key stakeholder consultation
 - consumer participation in the assessment of the youth friendliness of services and
 - a survey of staff perceptions of services.
3. Development of recommendations and an implementation plan for improved service delivery to young people.

An advisory committee including internal and external stakeholders was established at the onset of the project to inform and guide its direction. The staff was informed of the project's progress via regular updates and through staff representatives on the advisory committee. Recommendations were developed with input from the advisory committee, and were then presented to the FPV Board for final approval. Included in this report is the review of the relevant literature, which is the evidence-base, upon which (in conjunction with the audit data) recommendations were based.

Policy Context

International

It is timely to evaluate service provision to young people given that internationally, nationally and at State and local government levels, youth policy is being refined and efforts are underway to address the urgency of adolescent sexual and reproductive health. In addition, building an evidence base allows us to review the success of current programs, identify needs and gaps, and provides direction in determining future programs.

In 1990 adolescents' right to reproductive health was placed on the international policy agenda through the ***Convention on the Rights of the Child***, which obligates signatories to ensure young people have access to basic health, including reproductive health services. In 1994, this was expounded at the International Conference on Population and Development (ICPD) in Cairo, where governments agreed to provide adolescents with information and services to prevent unwanted pregnancies and STIs and to ensure they make the transition to adulthood in good sexual health. (CRLP, http://www.crlp.org/ww_iss_adolesc.html)

"The 1994 International Conference on Population and Development (ICPD) transformed the agenda for international family planning. The consensus forged in Cairo emphasized individual human rights over national development and population goals, redefined family planning as one element of comprehensive reproductive health care services, viewed health within a broader social context, and acknowledged the importance of equity and empowerment for women."

(RHO, http://www.rho.org/html/fpp_overview.html)

Through the Programme of Action developed at the ICPD, reproductive health care was defined as: *"the constellation of methods, techniques and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems. It also includes **sexual health**, the purpose of which is the enhancement of life and personal relations, and not merely counseling and care related to reproduction and sexually transmitted diseases."* (Programme of Action, 7.2 cited at www.undp.org/popin/icpd/conference/offeng/poa.html)

Two important objectives of the Programme of Action address sexuality and sexual health: *"To promote adequate development of **responsible sexuality**, permitting relations of equity and mutual respect between the genders and contributing to improving the quality of life of individuals."* (Programme of Action, 7.36a) and *"To ensure that women and men have access to the information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities."*

The Sexuality Information and Education Council of the United States (SIECUS) has expanded upon this definition of sexual health. *"Sexual health encompasses sexual development and reproductive health, as well as such characteristics as the ability to develop and maintain meaningful interpersonal relationships; appreciate one's own body; interact with both genders in respectful and appropriate ways; and express affection, love, and intimacy in ways consistent with one's own values."* (SIECUS, <http://www.siecus.org/policy/poli0002.html>)

The Programme of Action has set policy direction for strengthening our health systems by fostering sincere partnerships to improve S&R health for young people. Concerted efforts at all levels of government was called for to address the needs of adolescents, who need the tools, namely, skills and education to become sexually healthy adults. Key actions for young people are to: *"protect and promote the right of adolescents to the enjoyment of the highest attainable standard of health, provide appropriate, specific, user-friendly and accessible services to address effectively their reproductive and sexual health needs, including reproductive health education, information, counselling and health promotion strategies" (paragraph 73a). The challenge for the Programme is thus to fill gaps in what is known about the sexual and reproductive health needs and perspectives of adolescents, and to assess the feasibility and acceptability of different models that propose to enhance their access to information and services, and their life-skills, and in so doing, assist countries in identifying best practices and evidence-based adolescent-friendly policies and programmes.*

(RHO, http://www.who.int/reproductive-health/hrp/plan_of_work/fplanning.en.html)

Since the 1994 International Conference on Population and Development (ICPD) in Cairo, and the subsequent reviews of progress in implementing the Programme of Action developed there, there has been a call worldwide in relation to young people specifically to:

- Expand services to include the full range of sexual and reproductive health interventions and to

- Progress sexual and reproductive rights, especially with respect to young people

The World Health Organization (WHO), Director General, Dr Gro Harlem Brundtland believes there has been a paradigm shift in the approach to sexual and reproductive health from one of population control to a “rights” framework. Under her direction, the WHO has set a major challenge to improve adolescent sexual and reproductive health and warns of: *“...the costs of failing to ensure that young people - our common future - have the knowledge, skills and services they need to help them make healthy choices in their sexual and reproductive lives,”*

(WHO, http://www.who.int/director-general/speeches/1999/english/19990208_hague.html)

National Context

Getting It Right: Models of Better Practice in Youth Health, a report by the New South Wales Association for Adolescent Health, (Silk, 1999), documents best practice models in youth health service delivery. It offers a framework to guide models of health service delivery, as well linking the best practice models to the Innovative Health Services for Homeless Youth program (IHSY). Seven key processes were identified in a best practice model.

1. Addressing inequalities

- Advocating for redressing social inequalities
- Understanding the impact and mechanisms of social inequalities
- Working with communities to understand the causes of disempowerment
- Promoting advocacy and empowerment

2. Providing access and participation

- Developing service models that focus on incorporating mechanisms for access, support and participation of marginalized young people.
- Acknowledging the effect social inequity has on access to resources
- Increasing access by ensuring that the environment is geographically, physically, socially, culturally, aesthetically, financially and administratively available to all young people.
- Encourage youth consumer participation in program development
- Flexible modes of service delivery, including outreach, flexible fee structures and flexible opening hours.

3. Building supportive environments

- Provide an environment that encourages behavioural change as opposed to merely preaching it.

4. Balancing approaches

- Best practice health promotion needs a balance between direct and indirect services, as well as reactive and proactive approaches
- Often in primary health care the focus is on individual or group responses whereas a population based approach may be more appropriate for preventative initiatives.

5. Coordination

- Health practice should be multidisciplinary, holistic and should entail wide consultation and collaboration
- Multidisciplinary teams in youth health are better able to deal with the multitude of issues that interact leading to risky behaviours
- Coordination of services requires careful planning, documentation and evaluation so that services are not replicated
- Services should have a strategic marketing plan to increase community profile and trust within local communities.

6. Collaboration

- Inter-sectoral collaboration is required.
- The mutual benefits that arise out of outreach services and co-located services are important when trying to extend your reach to communities that are often difficult to target, however care should be taken to ensure useful links with mainstream health services are not underutilized.
- The settings based model such as health promoting schools are noted as being the most effective model when working with schools.

7. Building the infrastructure

- Supportive infrastructure that enables better practice requires access and linkages to research and tertiary based facilities that enable shared information exchange and forums to assist in developing or changing practices.
- Ensuring staff are equipped to deal with the multitude of issues young people face requires sociological and cross cultural training including gender ethnicity and class studies
- Basic orientation to the health agency is required by all staff to ensure homogeneity in the shared mission and vision of the organisation.
- Regular strategic planning is essential to keep up to date with the changing environment and the impact such change has on our work practices and programs.
- Professional support and supervision are essential to reduce the likelihood of burn out in the youth worker field.
- A comprehensive understanding of all policies and procedures is essential for staff and client safety.

State Context

The Office of Youth has recently been created to implement the Victorian State government's vision for young people across all government departments. It is located with the Department of Education and Training (DET) which should bring greater emphasis on cross sectorial collaboration between the Department of Human Services (DHS) and DET. The recently released Victorian youth strategy: **Respect: The Government's Vision for Young People. A Framework for Policy and Program Development** articulates the State government's commitment to improving health and wellbeing for young people, defined as those between 12-25 years. This document is intended to set out a framework for policy direction and program development and is based on three key principles: Respect, Diversity and Partnerships. Emphasis is placed on the need for collaboration, and recognizes that whilst government provides an integral role in program implementation and development, partnership building between service providers at all levels of government, young people and their families, is necessary for successful implementation of such a shared vision.

The most relevant platform to the purpose of this report is that of **Improving Access to Support Services** for young people. This document recognises that most young people enjoy health and opportunity and commits to providing those who are particularly vulnerable or "at risk" with the necessary support structures. It also states that creating supportive environments for young people depends on the provision of high quality services, education and health promotion. Emphasis is placed on youth participation, community strengthening, connectedness and building resiliency, academic/educational achievement and training for meaningful employment. There is little mention of the sexual and reproductive health needs of young people per se in this document, except in the context of emphasis on prevention of HIV/AIDS and Hepatitis C and the promotion of the physical, sexual, emotional and psychological 'safety' of young people. Yet, there is no stated measure of improvement set in this area. A future commitment is given to developing school based gender initiatives to improve relations between the sexes. This is an area where FPV may be able to adopt a collaborative approach to sexual and reproductive health promotion beyond the traditional sex talks. Primary Care Partnerships and Secondary School Nursing Programs are also mentioned as key places for collaboration to occur.

(DET, <http://www.youth.vic.gov.au/youth/pdfs/respect.pdf>)

City Context

The City of Melbourne has developed a social planning framework for the effective planning and delivery of services to all population groups. A continuum of care has been devised to take in to account different life stages, acknowledging that some groups have greater needs than others. The social planning framework allows the continuum of care to guide resource allocation within different life stages according to the level of need and existing service provision. The continuum of care model used by the City of Melbourne has enabled the City of Melbourne to offer programs to young people based on a formula of 20 % preventative programs, 20% participative programs, 20% early intervention and 40% intensive programs, thus catering to low and high needs groups.

The **Here And Now: Connecting Young People, Community and the City of Melbourne Youth Strategy 2001-2003** focuses on young people aged 13-21 years.

The Strategy states that: *“A city that supports young people provides planned and integrated services that are easy to access and are affordable, providing pathways away from risk and out of disadvantage.”*

A Review of Primary Care Services in the City of Melbourne (undertaken by the Centre for Development Innovation in Health, Australian Institute for Primary Care, Latrobe University) revealed that:

“The current service system appears very inadequate for these groups and the priority is for a major service initiative based in the CBD that can provide prevention and early intervention programs for young people who live in and who visit the city. The service needs to be able to respond to the needs of both females and males with a focus on illicit drug use, mental health and sexuality.” (Successworks, 2001p.22)

It was recommended that a CBD based primary health care service be established. Its focus should be on youth 13-24 and young adults 25-35 with high needs and to emphasise prevention, early intervention, support and restorative services. Ideally, the new service would be integrated with existing services through co-location protocols and planning arrangements and could be governed through an existing Community Health agency. (Successworks 2001) In another study of health services within the Central Business District, commissioned in 2001, it was confirmed that those with the highest needs were: Kooris, homeless, drug users, people from culturally and Linguistically Diverse Backgrounds and people with disabilities. Mental illness, violence, safety, lack of secure accommodation, inadequate services, poor physical and mental health and fractured relationships were further confounding. (Successworks 2001)

In relation to service delivery models the report advocated that:

“The nature of the population groups is such that emphasis should be outreach and flexibility in service delivery. The service should provide programs across the range of interventions, but with more emphasis on prevention, early intervention and on improving access to support and restorative services. The program should include strong health promotion and community development programs to build on strengths of young people.” (Successworks, 2001 P. 25) Furthermore: *The service will need to adopt flexible work practices and working hours including service provision in the evenings and on weekends.”* (Op Cit) After reviewing existing services to young people in the CBD: *“Council determined a “one-stop shop” for youth services in the city with supporting outreach services that are integrated or co-located with fixed location services is the most effective and cost efficient means of providing pathways away from “risk” and out of disadvantage.”* (Here and Now Strategy, 2000 P. 15)

The Frontyard Youth Service was recently redeveloped to create a co-located, youth specific service that offer an integrated and comprehensive range of services with a preventative and early intervention focus. Under the platform of a city that supports young people The City of Melbourne has committed to the establishment of a primary health care service in the CBD with a focus on meeting the needs of young people, particularly those identified as most disadvantaged.

S & R Health Services to Young People: Review of Literature

Adolescent Reproductive Health in Today's World

Largely due to the sheer numbers of adolescents currently making up the world population adolescent sexual and reproductive health concerns are at the forefront of international health agendas. Key issues of concern include sexually transmitted diseases, unwanted pregnancies, HIV rates and sexual abuse and exploitation, including trafficking of children and youth. (United Nations, http://www.unfpa.org/icpd/round&meetings/ny_adolescent/reportrt1.htm)

According to Fuller, interest in adolescent health and wellbeing has paralleled the decline of the same. Key areas of interest include adolescent suicide, depression, unplanned pregnancy, substance abuse and STD's. (Compass, 1995, cited in Fuller, 2002) Wholistic and integrated approaches to the reproductive health needs of young people are now recognized as the best way to protect and enhance sexual and reproductive health.

Demographics of Young People

In Australia, young people are relatively well off in relation to other countries, both developed and developing. Even so, as noted by the President of the Australian Medical Association:

"There are some concerning trends in the health status of young people in Australia and a need for innovative and creative ways to talk to young people and for their voices to be heard." (Phelps, cited in Rowe, 2002.)

According to the figures presented in ***The First Report On the Health and Wellbeing of Young People Aged 12-24 Years*** there is approximately 3,500,000 young Australians between 12-24, representing nearly one fifth of the total population. The number of young people is expected to increase, at least over the next ten years. Victoria has a population of about 4 ½ million with approximately 850,000 of them between the ages of 12-24, which is roughly the same proportion to the national figures. Close to 70 percent of young Victorians live in the Melbourne metropolitan region. There is an under representation of young people in rural areas. Aboriginal and Torres Strait Islander (ATI) young people make up about 2.1 % of the total population of Australia, yet they comprise nearly 20 % of the total of their communities. Health status for their communities is significantly lower than for the non-indigenous population and their death rates are significantly higher. Only about 15% of the current young people 12-24 were born overseas, despite nearly one quarter of all Australians being born overseas, indicating a large second generation cohort. Of the half a million young people born overseas the majority (about ½) were from an Asian country. (Moon, 1999)

Morbidity

Drawing on data reported in Moon et al (1999), in 1995 about 2/3 of young people described their health status as excellent or very good on a five point scale. Young women favoured their health status slightly more than young men.

The Burden of Disease (BOD) affecting young people is largely caused by life years lost due to disability rather than by premature death. The major Burden of Disease for young people 15-24 in 1996 (65% males and 85% in females) was non-communicable diseases. The leading cause of burden therein, was mental health disorders including

drug and alcohol dependence, and depression, which made up half of this. The second leading BOD was caused by injury, both unintentional (mostly road traffic accidents) and intentional, suicide or self harm. Young women are far more likely to be hospitalised for self harming behaviours but are less likely to die from them. (ABS, 2002)

Adolescence is often the time for onset of mental health problems. (ABS, 2002) A relationship between mental health, namely depression and suicide has been demonstrated. (Skegg, 1997, cited in Moon et al). Moreover, research overseas is suggesting that the incidence of mental health disorders is increasing. (ABS, 2002) Twenty percent of young people between 12-16, and 27 percent between 18-24, report mental health problems. (ABS, 1998, cited in Davies et al, 2001) In 1998, 33% of males between 14-19 years and 27% of females were regular drinkers. (ABS, 2002) Alcohol is strongly implicated in risk taking behaviours and is highly associated with motor vehicle accidents. Ramrakha et al, (2000, cited in Bennett and Bauman, 2000) identified increased sexual risk taking behaviours in adolescents with a range of mental health diagnoses, including the most prevalent, clinical depression. This has also shown to be true for those with substance abuse problems.

Bennett and Baumann pointed out that particular attention should be paid to high risk adolescents given the frequent co-occurrence of high risk behaviours. Such risks relate to adolescents with mental health problems and early school leavers. Young people who drop out of school have special and complex needs, with extremely high rates of sexual behaviour, mental health problems, and drug abuse. (Tressider et al, 1997, cited in Op Cit, 2000)

Mortality

In 1997, of the 2100 young people who died in Australia, 2/3 were male and 2/3 were due to either accidents (including road accidents and suicide), poisonings, or violence, making these factors the leading causes of death for young people between 12-24. Due to a range of interventions, all death rates for young people are declining, except in the case of suicide, particularly concerning young men between 15-22 and those in isolated townships. There has been a four fold increase in the suicide rate from 1960-1995, mainly for young people over 19 (Davies et al, 2001) Despite suicide rates for young people between 15-19 remaining relatively stable in more recent years. (Steenkamp and Harrison 2000, cited in ABS, 2002), sadly, Australia has one of the highest rates in the world. (Moon, P. 69)

What are the Issues for Young People in Australia?

Even though young people enjoy relatively good health, in comparison to other age groups within Australia, there are certain issues which put them *“at risk of other ill-effects”* (Moon, 1999). Based on the available statistics, the Australian government has established priority groups which are disproportionately at risk in comparison to other young people and who experience lower health status. Such young people are from the following backgrounds: Aboriginal or Torres Strait Islander, rural and remote communities, overseas born and those who are socioeconomically disadvantaged. (Moon, 1999) In the context of applying a social model of health to solve health issues facing young people, and in order to adopt a required whole of sector collaboration to do so, it is important to have a clear understanding of the overall issues concerning young people's health status.

Major issues affecting young people have been identified as conflict, alcohol and drug taking and sexual activity. (Here and Now Strategy, 2000) Key issues for young people identified by the NAAH are: Sexual Health, Mental Health, Self-Harm and Injury, Alcohol and Other Drugs and Sexuality. (NAAH website) In a recently released report which examined the health and welfare status of young Victorians in rural and regional areas, it was noted that rural Australians face lower socioeconomic and health status compared to their urban counterparts. (Davies et al, 2001) Regional Youth Councils identified priorities for young people in their communities which in order of importance were: drug and alcohol issues, depression, suicide, anxiety and sexual health. Furthermore, Same Sex Attracted (SSA) young people were deemed particularly at risk in these areas, experiencing higher drug dependence, homelessness, depression, suicide, and STI's. (Op Cit, 2001)

Sexual Health Issues for Young People

According to advocates for adolescent health, reproductive health needs of this group have largely been neglected.

"...adolescents have sexual and reproductive health needs that differ from those of adults in important ways, and which remain poorly understood or served in much of the world. Neglect of this population has major implications for the future, since sexual and reproductive behaviours during adolescence have far reaching consequences for people's lives as they develop into adulthood. (Department of Reproductive Health and Research (RHR), World Health Organization, <http://www.who.int/reproductive-health/adolescent/index.html>)

One explanation for this is that: *"adolescent sexual and reproductive health rights and needs remain culturally and politically sensitive topics, and there is a dearth of evidence on best and workable practices in different settings that cater to their particular information, life-skills and service needs in acceptable and effective ways."*

Teenage pregnancy and sexually transmitted diseases, particularly HIV are key sexual and reproductive health issues for young people globally. The main issues in adolescent sexual and reproductive health are:

- Sexual development and sexuality (including puberty)
- Sexually transmitted diseases/ HIV/AIDS
- Unwanted and unsafe pregnancies (WHO, <http://www.who.int/child-adolescent-health/ashr.htm>)

Australia has a strong history of providing sexual health services and school based sexual education. (DHS, 2, 2000) In spite of this, there is concerning evidence that sexual activity, along with other risk taking behaviours in young people has increased over the past 20 years. (DHS, 1, 2000) Teenage pregnancy was more than halved between 1971 and 1988 to 20 births per 1,000 women. Changing social circumstances such as community acceptance of contraception, application of abortion laws, sexual education and changes in the practices of GP's have contributed to this drop. (Moon, 1999) Of the developed countries, Australia, along with Canada and Great Britain, has a moderate level of teenage pregnancy and birth rates at 40-69 per 1,000. This is in contrast to the United States where the rates are high and Sweden and France, who have the lowest rates. (AGI, http://www.alanguttmacher.org/pubs/euroteens_summ.pdf)

Table 1. Pregnancy rate, abortion rate and birthrate, by category

Table 2. Pregnancy rate, abortion rate and birthrate, by category		
Category	Pregnancy rate	Abortion rate and birthrate
Very low	<20.0	<10.0
Low	20.0-39.9	10.0-19.9
Moderate	40.0-69.9	20.0-34.9
High	70.0-99.9	35.0-49.9
Very high	>=100.0	>=50.0

Table 2. Australian Adolescent Birth Outcomes, 1994

Table 3. Rates of adolescent birth, abortion and pregnancy per year (per 1,000 women aged 15-19) and abortion ratio (per 100 pregnancies), by developed country, for the most recent year available				
Country	Birthrate	Abortion rate	Pregnancy rate	Abortion ratio
Australia	19.8	23.8	43.7	54.1

Using data from 1994, Australia was compared to other developed nations in terms of birth, pregnancy and abortion rates for young women between 15 -19 and categorised accordingly. As can be seen, Australia has a moderate teenage pregnancy rate of 43.7 per 1,000 females. The abortion rate is also moderate at 23.8 per 1,000 pregnancies but is still significantly higher than Great Britain at 18.6 per 1000 and has increased between 1985 and 1996. (Singh and Darroch, 2000)

In 1997, 5% of all live births were to teenagers and 9% were to women between 20-24 years. Teenage fertility has declined since 1971, due largely to improved social and economic factors affecting women's lives. (ABS, 1998, cited Moon, 1999) Abortion is often used as an indicator of a lack of access to information/knowledge of sexual and reproductive health. There is a lack of good data nationally regarding terminations of pregnancies, but it is estimated that approximately half of all pregnancies in teens end in an abortion. (AIHW, 1998:52, cited in Moon, 1999) Sexual Health issues in rural areas, even though largely the same, play out differently for young people due to the geographic barriers to appropriate services. Anecdotally from recent consultations in rural Victoria there is an increase in teenage pregnancies which is often equated with poor access to health and social services. (Davies et al, 2001)

In relation to the onset of sexual activity, in 1997 the Australian Research Centre for Sex, Health and Society (ARCSHS) conducted a nationally representative, school based study with students from years 10-12. They found that most young people begin sexual relations around the age of fifteen, and very few are active before this except for 11% of males and 9% of females. By the age of eighteen however, over 55% of males and 58%

females are sexually active. (Moon, 1999) A 1995 National Health Survey revealed that choice of contraceptive by women varies across age groups. Around 66% of women between 18-19 chose the pill, which increased to 71% for 21-24 year olds. 33% of 18-19 year olds used condoms but this decreased to 21.6% for women between 20-24. In the 1997 ARCSHS school based study with students between years 10-12, 7% of males and 10% of females reported being attracted to the opposite sex (Lindsay et al, 1997, cited in Moon, 1999).

Sexually transmitted diseases (STD's or STI's) are considered a major public health problem around the world. (Panchaud et al, 2000) Young people are more likely to acquire an STI than any other age group. (NSW website) Syphilis, gonorrhoea and Chlamydia disproportionately affect young people, who account for more than one-fifth (and often more than one-third) of reported cases of these three diseases. (AGI, http://www.agi-usa.org/pubs/fb_teens.html) In Australia, certain notifications of STI's such as the rate of syphilis has also dramatically decreased to 11 per 100,000 in 1997. (Moon 1999) Yet still of major concern is the rate of Chlamydia in this age group which is the main STI affecting young people, especially young women. Notifications have increased nearly threefold between 1991 and 1998 but it is not known whether this increase is attributable to improved testing and notification procedures.

The incidence of HIV infection for young people decreased between 1991 and 1998 to three cases per 100,000 for young men and one for young women. Students' knowledge of HIV infection was better than that of other STD's and overall, older students and young women were more knowledgeable on sexual health matters. (Lindsay et al, 1997, cited in Moon 1999) Despite good knowledge of transmission of STD's, particularly HIV amongst young people, condom usage is not uniformly practised. Increasing condom usage is a key strategy to protecting young people from the harmful effects of acquiring an STI, including HIV. In the same school based study conducted by ARCSHS, less than half of all students in Year 12 reported ever using a condom during sexual activity. Young women reported that they were less likely to always use condoms than young men. (Lindsay et al, 1977 cited in Moon, 1999)

Barriers for Young People Accessing S&R Health Services

Barriers to health care for young people continue today and have been well documented in the literature. The main barriers relating to young people accessing health services include location and hours, provider attitudes and quality of service, confidentiality and privacy, gender of provider for young women, cost of services and how youth focused the service is. Young people are reluctant to access GP's for sexual and reproductive health issues largely due to fears with confidentiality, cost, judgemental attitudes and fears of serious illness. (YACVIC, 2001) Thus, even though young people are at a stage in life where many are sexually active, they often face barriers to obtaining relevant services.

Barriers for young people specifically accessing sexual and reproductive health care are better understood via practice wisdom than are documented in the literature. Generally young people's negative perceptions of S&R clinical services are similar to those towards seeking primary care services. They may be judgmental, unwelcoming or insufficiently confidential. In addition, practical barriers include inappropriate geographical location, hours of operation and the need for an appointment.

“Potential family planning clients may face a variety of barriers. For example, the cost of transportation, services, and supplies may be unaffordable; they may not know where to seek services; or they may fear side effects too much to act. In some settings, conditions at the service delivery point discourage clients from seeking services; family planning clients have complained about limited hours, long waits, rude treatment by clinic staff, and unreliable supplies of contraceptives.”

(RHO, http://www.rho.org/html/fpp_overview.html)

Thus, the combination of risky sexual activity with, often, a lack of both information and access to services, makes adolescent reproductive health a research priority. (WHO, http://www.who.int/reproductive-health/hrp/progress/41/news41_1.en.html) Research methods also need to be developed for assessing policy and program changes, especially where changes are intended to make programs more "youth-friendly". (WHO, http://www.who.int/reproductive-health/hrp/progress/47/news47_2.en.html)

Principles for Reaching Young People

Guiding principles to ensure the provision of culturally appropriate services responsive to young people's needs, as outlined by the New South Wales Association for Adolescent Health include:

- *“A multi-dimensional approach and counseling, medical services, group work, outreach services, health promotion and the provision of health information and resources.*
- *Health Promotion strategies should be diverse and include community development, health education, assist in building public policy and develop personal skills.*
- *Services working with young people should work towards better practice models, specifically in regards to confidentiality policy and practice, duty of care and the development of codes of behaviour for staff and clients within their services.*
- *Services working with young people should strategically develop partnerships and working relationships with organisations, agencies and individuals in their local communities. These partnerships should enable a more effective response to the local client groups.*
- *In the development of services and programmes addressing the health needs of young people, services should ensure that participation principles be a key feature of program development, implementation and evaluation.”* (NAAH, <http://www.naah.org.au/wellbeing.htm>)

Some of the key ingredients underlying successful models for service provision to young people in rural areas were outlined in Rural Lives of Us. (Davies et al, 2002) These included services that offer:

- A single entry point
- Resources, activities and events
- Multiple access modalities
- Wellness promotion
- Youth-driven programs
- Co-located services, such as youth development workers, employment, school, recreation, health

- Youth friendly environment
- Café-social environment
- Local buy and/or coordination by local government
- Mentoring adult-youth approach
- Involvement of local media

The Reproductive Health Outlook has reported guidelines on building successful programs and reaching marginalized young people based on their rigorously evaluated S&R health projects from around the world. They conclude that:

“Well-designed youth programs consider the many factors that shape young people's lives and influence sexual behavior and reproductive health decision-making.

- *Key strategies for reaching and serving youth include:*
 - *developing youth-friendly services;*
 - *involving youth in program design, implementation, and evaluation;*
 - *training providers to attend to the special needs and concerns of adolescents;**and*
 - *encouraging community advocacy efforts to support youth development and promote positive adolescent health behaviors;*
 - *implementing programs that provide complete and accurate sexual health information;*
 - *incorporating skill-building exercises into youth programs to help young people improve their self-esteem, develop communication skills about sexuality, and strengthen their ability to negotiate safer sexual practices.*
- *Adolescent programs work best when they provide life skills education in addition to sexual health information and services ([WHO/UNFPA/UNICEF, 1999](#)). Programs should help young people develop skills and talents that offer them opportunities for economic viability and develop their sense of having a potentially successful adulthood. Such opportunities, combined with reproductive health information and services, can help motivate youth to postpone sexual activity by helping them understand the long-range impact of their decisions and the importance of planning their futures.*
- *Both young men and women may need reproductive health education, including information on sexuality, contraception, reproduction, abstinence, abortion, STDs, and gender roles.*
- *Adolescent sexuality is a sensitive subject in all cultures. Programs that offer reproductive health services to adolescents can expect to encounter some resistance from their community.”*

(RHO, http://www.rho.org/html/adol_overview.htm)

Service Delivery Models for S&R Services to Young People

A review of the available literature on effective models of sexual and reproductive health services has revealed a general division between direct clinical service provision and health promotion such as sexual education and prevention programs. With the increasing rates of STI's, particularly through the 1990's with HIV, interventions increasingly evolved to prevent these. Also due to the increase in sexual risk taking behaviours and their cost effectiveness, emphasis in service delivery has been placed

on preventative programs. The most prominent issue for delivering direct services to young people has been on improving access to care. (Brindis, 1995) Evidence from around the world has clearly shown that providing information and building skills on human sexuality and human relationships helps avert health problems, and creates more mature and responsible attitudes. (Brundlandt, WHO) Moreover, health promotion programs are producing lasting behavioural changes in their target groups. (DHS, 1, 2000) Specifically, evidence shows that school based prevention programs can reduce high risk sexual behaviour, such as unprotected sex. (Kirby, 1994)

In a review of the evidence base for adolescent health promotion strategies, programs using community mobilisation strategies and peer based interventions and education were more likely to be effective. (DHS, 2., 2000) One successful program cited (Kegeles, 1996) was a peer led, community based program that incorporated outreach, small groups and a media campaign. Another older peer led/mentoring based program from Norway applied in the school setting has had successful outcomes in sexual education to younger students. (DHS, 2., 2000) Peer education strategies to reduce sexual risk taking creates more youth friendly approaches. (DHS 2000)

Expanding sexual and reproductive health services offered through primary health clinics such as those school based, combined with comprehensive sexual education have shown to be effective in improving access and availability of contraceptives and condoms to young people. (DHS, 2., 2000). Prevention and intervention programs that combine strategies such as peer based plus media or social marketing are more likely to produce desired effects. This report concludes that schools are a promising location for expanding prevention efforts of sexual risk taking behaviour and advises to target specific behavioural indicators to maximize program effectiveness.

"If the main aim of a program is to reduce the rates of adolescent pregnancy and sexually transmitted diseases (including HIV/AIDS), then it should focus on reducing unprotected sexual intercourse. Single programs that are comprehensive and include issues of pregnancy and sexually transmitted diseases are also likely to be more effective". (DHS, 2., 2000, p15.) From the review of adolescent health promotion it would appear that DHS is particularly interested in further developing community mobilisation strategies, addressing co-occurring adolescent risk taking behaviours such as drug and alcohol taking and sexual risk taking behaviours.

In their review of programmes to improve availability of S&R services to young people in the United Kingdom, many of the approaches taken to address key concerns have used a top-down approach, using adult facilitated risk and lifestyle issues. (Senanayake, P, Nott, JH, Faulkner, KM, 2001) These models have been criticized as they have a tendency to problematise issues and focus on the negative aspects of adolescent behaviour, viewing young people as: *"collections of discrete problems"*, and ignore building their capabilities. Other criticisms of this approach are that there is also a tendency to homogenous young people, rather than emphasise their differences which removes the real issues from the real context of young people's lives. (Op cit) The authors advocate that S&R service providers must move away from a risk focused, top down approach to one that is driven by young people themselves, highlights their needs and rights and views them in their proper socially complex context.

Generally prevention programs have taken a single issue focus, such as pregnancy prevention. (Kirby, 2001) Despite the large numbers and variations of pregnancy prevention programs there is a lack of data on effective programs and components thereof. (Franklin and Corcoran, 2000) In the United States, efforts to reduce high rates of teenage pregnancy have led to emphasis on abstinence or delaying sexual activity based models. Australia has been more flexible in its approach to teenage pregnancy prevention and has a long history of school based sexual health education. (DHS, 2000) In light of these differences the varying teenage pregnancy rates between the U.S. and Australia are notable. The United States of America has the highest rates of pregnancy, abortion and birth of any developed nation. (Maynard, 1996, cited in Lober Aquilino and Bragadottir, 2000)

Review of programs often occurs based on locus of intervention, such as school based, community based, clinic/non-clinic, or the type of intervention whether it is, sex and sexuality education, abstinence based, contraceptives included, skill building, duration of program, such as short (<10 hours), medium (10-40 hours), comprehensive (more than 40 hours), peer education, intergenerational i.e. including parents and so on. (Franklin and Corcoran, 2000) Within these programs they can be categorized into those that aim to offer information to either prevent first time pregnancies to young people (primary prevention) or to provide services and prevent subsequent pregnancies with young parents. (Hofferth, 1991, cited in Franklin and Corcoran) Franklin and Corcoran, (2000) examined best practice models of adolescent pregnancy primary prevention programs, based on outcomes including measures of:

1. changes in sexual knowledge and attitudes, such as understanding use of contraceptives, or change in attitudes on delaying sexual activity, usually assessed by pre and post intervention test measures.
2. increase in interpersonal skills such as communicating strategies, usually assessed by follow-up questionnaires
3. changes in sexual behaviour, delaying or reducing frequency of sexual activity and increased use of safe sex practices which is usually assessed using self reports and by examining pregnancy rates.

Behavioural indicators of outcomes are widely considered superior measures of effective prevention programs. (Franklin and Corcoran, 2000) A meta-analysis of teenage pregnancy prevention programs concluded that: programs based in clinics were more successful, as were community based clinics, whereas school based sexual education programs were more successful than those offered in the community. Programs which included contraceptive knowledge building and distribution, as well as skills training were more effective. Comprehensive and age appropriate curricula are important to address developmental issues especially for young teens who are not yet sexually active. Curricula incorporating social learning theory principles such as skill building, role modeling and peer education are more likely to produce behavioural impacts on sexual risk taking. (Franklin and Corcoran, 2000)

Peer based education models have increased in popularity in both the United States and the United Kingdom but much of their success is still based on working hypotheses rather than good program evaluation findings. (Milburn, 1995) It is widely accepted that peer education is effective in delivering sexual health messages, as adolescent sexual activity is highly influenced by attitudes and behaviours of their peers. (Whitbeck et al,

1993 cited in Milburn, 1995) Three main reasons cited for choosing peer based methods for delivering a diverse range of health education messages to young people are efficacy, efficiency and empowerment. (Op Cit, 1995)

Program development in this area needs careful process and outcome evaluation, particularly when examining behavioural changes. Careful consideration should also be given to setting, age, gender and ensuring accuracy of information being passed on. Such programs are often resource i.e. labour and time intensive for workers. Some programs required highly skilled workers to conduct intensive training and provide ongoing follow up to peer educators over the longer term. Peer educators often gain more in the way of benefits from participating in meaningful roles and gaining critical social skills than can be actually demonstrated in behavioural change within the target group. (Milburn, 1995) Turnover of peer educators can mean program success may be short-lived. There was some evidence given in Milburn's review of peer based programs that they are effective in targeting high risk young people via outreach programs, such as with young women from CALD backgrounds in disadvantaged, urban settings (Slap et al, 1991 cited in Milburn, 1995) and with street workers (Campbell, 1991, cited in Milburn, 1995).

Di Censo et al observed in a review of teenage pregnancy primary prevention programs that *"few sexual health interventions are designed with input from adolescents"* (Di Censo et al, 2001, cited in 2002 p. 1433). Young people continue to be one of the few identifiable health consumer groups that have little or no input into the provision of their health care services, despite evidence that this a core component of successful, youth friendly programs. When rural and urban adolescents were asked what they wanted from sexual education programs they wanted it to be *"more positive with less emphasis on anatomy and scare tactics; it should focus on negotiation skills in sexual relationships and communication; and details of sexual health clinics should be advertised in areas that adolescents frequent (for example, school toilets, shopping centres)"*. (Op Cit) Peers and media were given as the main sources of information even though these were not always accurate and participants generally had limited knowledge of S&R health services available.

Risk and Resiliency focused models of youth health promotion have come to the forefront of adolescent health. Fuller described resiliency as "bungee jump through the pitfalls in life" (Fuller, 2000 p13.) or is the ability to rise above adversity, especially those influences one's environment throws up. In efforts to promote resilience in young people, research has focused on how to increase protective factors and reduce risk factors. Factors identified that promote resilience relate to creating a sense of belonging and connectedness for them within their social context via family, friends, schools and communities.

Kirby, (2001) in a review of 73 teenage pregnancy programs in the United States focused on identifying risk and protective factors for adolescent sexual risk taking. As well as identifying key components of successful programs he also identified key risk factors for sexual risk taking. These included community disintegration such as poverty, low socioeconomic status and educational attainment and high unemployment; family dynamics, structure and values; peer and partner influences; individual factors such as age, hormone levels; engagement in other high risk activities such as substance abuse; degree of involvement with school and community; and past experiences of sexual assault. Berne and Huberman (1999) concurred that *"poverty is significant to adolescent*

sexual health indicators because of its association with adolescent pregnancy and its impact on youth goals, aspirations and risk behaviours" (Luker 1996, cited in Berne and Huberman, 1999 p.9)

In reviewing his earlier work, Kirby proposed the social norms-connectedness framework to explain much of adolescent sexual risk taking, as well as other high risk behaviours. The norms held by those around the young person, family, friends/peers, and partners, strongly impact on their behaviour. Greater connectedness to groups that express clear norms about responsible sexual behaviour by family, school and community groups tend to protect young people more from sexual risk taking. Thus, such ties need to be fostered. He also noted that, of the sexual education programs, those that were most effective gave clear messages about avoiding unprotected sex. While at the same time engaging with them about its relevance in their lives and increasing their self efficacy skills.

Kirby also identified the importance of staff with particular personal qualities who can relate to young people and who they can find credible. He concluded that: *"Developers of programs should be aware of the importance of giving a clear message, of trying to get youth to adopt responsible norms, of increasing connectedness between staff and youth, and of increasing connectedness between youth and other youth or adults who express clear and responsible norms."* (Kirby, 2001, p. 280)

In addition to working at this interpersonal level, Brindis stressed that: *"resolving the problem of teenage pregnancy will require a major and coordinated effort aimed not only at adolescents themselves, but also at the political, economic, medical, educational, and religious institutions whose systems and policies profoundly influence the underlying conditions that lead to adolescent pregnancy and child-bearing."* (Brindis 1999)

Not all the evidence suggests that primary prevention programs are effective and calls for careful attention to program design and evaluation. Di Censo et al. (2002) examined interventions to reduce unintended pregnancies among adolescents via a systematic review of randomised controlled trials. Using strict criteria which only included purely experimental trials (most programs reported in the literature are quasi experimental in that they don't randomize subjects to a control or experimental group), they concluded that *"primary prevention strategies evaluated to date do not delay the initiation of sexual intercourse, improve use of birth control among young men and women, or reduce the number of pregnancies in young women."*

The authors acknowledged that such interventions are very limited in their capacities to address the complex, multiple, and ongoing influences of parents, peers, health services providers, schools, socioeconomic conditions, religion and the media which shape the values, beliefs, and attitudes determining youth sexual risk-taking. (Di Censo et al. 2002)

Prevention programs that offer a broad range of services and address multiple high risk behaviours have greater potential to impact adolescents' behaviour than those that are single issue focused. Interventions must also be multilevel to address the other risk factors not seemingly affected by norms and connectedness such as community disintegration. (Kirby, 1997, cited in McBride and Gienapp, 2000) There is also some dispute in the literature over this latter point, as some researchers believe that, while supporting young people with a range of needs, it is important to focus on the single issue of sexuality and pregnancy prevention. (McBride and Gienapp, 2000)

Dryfoos, in an assessment of what works with at risk young people to change high risk behaviours, such as preventing early initiation of substance abuse or sexual activity, acknowledged that there *are “no magic bullets for changing either personal or institutional behaviour.”* (Dryfoos, 1991, p. 631) Nevertheless, she identified two common themes in successful models: Individual attention and multilevel, community wide programs. Other successful components include early intervention, educational achievement and social skills building, proactive school based programs, parental involvement, peer involvement, connected to young person’s wider social context such as employment and well trained and supported staff. (Dryfoos, 1991) Some evidence suggests that reorientation of health services to provide outreach to at risk groups can be effective in impacting on sexual risk taking behaviour. (DHS, 2, 2000) However, the mere availability of health care services to high risk young people does not ensure their access, especially by those most “at risk” but proactive, targeted outreach can be effective in bridging the gap. (Vaughn et al, 1996) It has been recommended that programs create a hierarchy of risk and tailor their programs accordingly.

Risk Continuum

When designing effective programs for the delivery of sexual and reproductive health needs, planners need to be aware of the differing factors that impact on individual lives, such as stage of development, level of sexual activity and socio-cultural environment in which they live. While all young people may be at risk of an unhealthy consequence of sexual activity, some are more at risk than others. It may therefore be helpful to develop a continuum of risk for planners to follow when devising programs to meet the needs of different groups. Hughes and McCauley (1998) developed an analytical tool for program planners. The framework categorises young people into three groups:

1. Young people that have not begun having sexual intercourse
2. Young people that have engaged in intercourse but have experienced no unhealthy consequences.
3. Young people that have engaged in intercourse and have experienced an unhealthy consequence such as an STI, an unplanned pregnancy or an unwanted sexual experience.

Table 3

Group services	Generic skills^b	SRH skills	SRH
Group 1: Not yet sexually active ^a	Seeking help and information Decision making Planning ahead Negotiating	Communicating about sex Avoiding unwanted sex	Providing information on such topics as sexuality, reproductive health, hygiene, relationships Individual and group counseling as needed
Group 2: Sexually active without unhealthy consequences	Same as for group 1.	Same as for group 1, plus: using contraceptives correctly Using condoms correctly Developing parenting skills as needed	Same as for group 1, plus: STD/HIV screening Providing choice of contraceptive methods Pregnancy testing
Group 3: Sexually active, with unhealthy consequences	Same as for group 1,	Same as for group 2	Same as for group 2, plus: STD treatment Antenatal delivery and post natal care

^a= Sexually active refers to having sexual intercourse

^b=The skills and services listed are examples only

^c=SRH sexual and reproductive health

Note: In addition to differences in sexual experience, programs must also take into account other key differences among young people, such as sex, age and marital status (WHO and UNICEF, 1996; Hughes and Berkeley, 1998) (Hughes and McCauley 1998).

This tool may be useful in tailoring programs and developing clinic protocols but it is imperative that other risk and protective factors are considered that contribute to pushing an individual along a scale of either high risk or low risk.

Bennett proposed that even though a great deal has been learned about adolescent risk and resiliency and fostering connections with family and school, the challenge for clinicians is to address the health issues of young people in a sensitive and comprehensive manner. He referred to the HEADSS exam, a mnemonic for home, education, peer activities, drugs, sexuality, and suicide as a helpful assessment and screening tool that can assist the clinician with focusing on concerns, feelings, and behaviours. Given the complex interplay between mental health disorders and high risk behaviours, the need for coordinated health care for young people covering psychological, sexual, and social aspects was emphasised. (Bennett and Bauman, 2000)

Findings from risk focussed approaches have lead to greater emphasis on early intervention and prevention strategies which have increasingly become reflected in government policies. This is evidenced in Australian literature too, based on work developed in the United States and applied to the Australian context. The recent report ***Improving the Lives of Young Victorians in Our Community***, (DHS, 1, 2000), details findings from a survey of risk and protective factors. The main findings highlight the strong link in our communities between the number of risk and protective factors to which a young person is exposed and their engagement with high risk taking behaviours and the co-location of such risk factors. (DHS,1, 2000) Risk factors were grouped into four main areas of a young person's life: Community, School, Family and Individual/Peers. Such a risk-focused approach to health promotion has strong implications for the kinds of interventions needed to effectively impact and reduce risk taking behaviours.

Communities that Care is one such strategy, used successfully in local communities in the USA and UK, it targets these four main areas. Using local evidence of key risk and protective factors for young people, it offers a planning framework for tailoring community based programs with emphasis on prevention and early intervention. (Fiske, 2000) Research has shown that:

1. Comprehensive prevention and early intervention benefits the community
2. Changes in rates and patterns of youth behaviours require different service responses
3. No single agency can affect a major improvement in youth outcomes
4. Early intervention is a cost effective investment

After extensive review of Victorian youth services and the programs overseas, the CTC risk-focused framework has been accepted as appropriate for the Victorian context. (DHS,1, 2000) The Victorian Government is interested in the CTC risk framework to address gaps in the provision of early intervention and support services, establish stronger cross-program and interagency linkages for responding to critical socioeconomic factors affecting young people. (Fiske, 2000)

Reaching Young People in Rural Areas

Warr and Hillier (1997), in a survey that engaged young people in rural communities around Australia, found that even though rural life was generally positive, there were specific concerns in regards to their sexual health. Privacy and confidentiality were of key concern, as was their sexual reputations being jeopardized by safer sexual practices, particularly for young rural women.

Rural Lives of Us, (Davies et al, 2000) explored the health and welfare issues facing young people, and those working with them, in rural Victoria and highlighted the importance of acknowledging diversity within and between rural, regional and remote areas. The heterogeneity of rural communities needs to be considered in developing programs and policies.

In regards to service models for rural youth services, it also acknowledged that there was no one-size-fits-all or magic bullet. Generalist youth services were more likely to succeed by being able to work across a broad range of sectors and offer flexibility. In

this regard, training of rural youth workers in sexual and reproductive health should be a priority. Outreach was considered a good model for rural service provision to overcome access barriers, although this creates increased overheads for an organisation. “Inreach” models, which are the opposite to outreach, creating a central nexus service or one-stop-shop, may also work, however they must be staffed around the clock, provide a range of services and benefit from consumer participation in the management of the program. (Davies et al, 2000)

Key factors to be considered for program development, particularly in rural areas are that they take into account:

1. Relevance and applicability of services to the location and specific needs of regional areas.
2. Coordination between services at a service delivery level as well as infrastructure, management and service planning levels.
3. Commitment to whole of community, cross-sectoral and collaborative approaches. (Op Cit)

FPV has already demonstrated its ability to deliver successful prevention programs in rural communities. This is illustrated through the SSAY Something project developed in rural Victoria in which the model established a local reference group of key agencies and individuals; provided specialist training, delivered through existing efforts and focused on practical initiatives for agencies to undertake in their work; worked with a local school to establish a program for students focusing on sexuality issues from a mental health perspective; established a support program for gay, lesbian, bisexual and questioning youth; and recommended a community forum looking at mental health issues for rural same-sex attracted young people. Finally, the reference group identified another key component to the success of the program as the development of a support program for parents of their gay, lesbian or bisexual children. (Seal, 2001)

Key principles applied in this approach were that the project was:

- owned by the local community
- increased the networking opportunities
- spread the workload across a number of people and agencies
- was sustainable beyond the funded period
- created opportunities for on-going support from local agencies and
- established credibility across the health, youth and welfare sectors.

“The particular experiences of the SSAY Something Project illustrate the veracity of these key learnings, and the importance of strategic, yet flexible models that reflect community development approaches to change.” (Seal, 2001, p. 15)

Direct Clinical Service Models

In relation to direct service provision to young people, access to care features in the literature as the most pressing service delivery issue. (Brindis, 1995).

“Family planning programs have developed innovative approaches to delivering services. Strategies have included locating additional clinics in under-served areas or centralized locations, taking services to target groups via mobile clinics and community-based distribution workers, selling contraceptives at a subsidized price and training private-sector providers. However, true access requires more than conveniently located services.” (RHO, http://www.rho.org/html/fpp_overview.html)

Phelps, (2002) referred to models of adolescent health care as “patchwork at best”. (CAH Conference 2002) The Centre for Adolescent Health has described six models for adolescent service delivery. (Davies, 2000, cited in Cuneen, 2002)

1. Youth Specific Service within a health or youth service e.g. community health centre.
2. Adapting a mainstream health service to be more youth friendly
3. Outreach from a youth service, such as the Cutting Edge Youth Service’s The Big Red Bus.
4. Inreach models- flipside of outreach is creating a central nexus service or one-stop-shop.
5. Youth health service co-located with other youth specific services
6. Standalone youth health service
7. Telephone and internet service

The consultants Success Works, described the Clockwork Youth Health Agency in Geelong as a successful model for adolescent care. It is a co-located youth agency, situated in a youth precinct with art, community, health and eating facilities, with a service design specific for adolescents in addition to mainstream health services. (Cuneen, 2001) Co-location of services has become the most popular model of service delivery to overcome access barriers and capture youth in the one-stop-shop approach. However, as documented in the redevelopment of the Frontyard Youth Service “co-location” in and of itself was not the solution to improving integrated service delivery to young people. Experience has told that it may lead to a less than satisfactory service model due to arising fragmentation, philosophical differences, differing contractual and funding agreements and standards for working with young people. Instead, *“integration of services with a common vision, mission, shared philosophy and agreed protocols and professional practice guidelines”* was considered a model of best bets. (Success Works, 2000 p.38) Principles that facilitate successful co-location identified by Chesterman Associates, (1998, cited in Success Works, 2000) included that services share a:

1. Compatible service delivery philosophy and framework
2. Complementary approaches in dealing with clients and a
3. Common community of interest

The High Street Youth Service in NSW, serves young people primarily 12-25 who are at risk, but will serve all young people who access the service. Based on a philosophy of social justice and a social view of health, they have adopted a broad based model, rather than one that is problem based, to reduce risk taking behaviours. They:

1. Link youth development and health outcomes
2. Promote an understanding of processes that motivate young people to adopt health achieving behaviors
3. Adopt a resilience based positive youth development model in which development is seen as a process not just an outcome. (Short, CAH Conference 2002)

Research documenting the success of models delivering sexual and reproductive health services to young people is scant. One study in the United Kingdom evaluated S&R health services at two satellite sites, one for young people and the other an open age mainstream clinic. They piloted an alternative approach to running the two parallel services by establishing one quality mainstream service. This service was open to all ages with extended hours, required no appointments and built in a drop in component, combined with targeted outreach to facilitate access to the under 25's. The outreach program included developing strong links between the schools, youth services, social services and voluntary sector organisations. By establishing a new, single quality service model with targeted outreach to young people, they saw new patient registrations increase among all age groups almost immediately. The greatest increase was seen amongst the younger age groups with a 12 fold increase for those under 16, a three fold increase for young people between 16-19, and 2.5 times increase for those under 30.

The combination of extended clinical hours, drop in and proactive targeted outreach significantly increased the use of family planning services. Targeted services aim to meet the needs of specific client groups, whilst the mainstream service aims to meet the needs of a range of users. Mainstream contraceptive services are attractive to young people if they are of high quality and they are initially accessed via a targeted outreach service. By prioritising the needs of young people one is assuming these groups have homogeneity of need, which may only exist in their need to access high quality services. It may be better to look at the differing needs within subgroups of this population such as age, gender, sexual experience and ethnicity. (Baraitser et al, 2002)

Gender Issues in Service Delivery to Young People

Family Planning Services have traditionally served women who historically, have been socially responsible for contraception. Still today, the vast majority of FPV clinical service users are women.

“Reproductive health programs are becoming increasingly aware of how cultural norms and social roles shape women's health, including their sexuality and behaviour. Limited access to resources and limited control over their own sexuality make women vulnerable to sexual exploitation, violence, unwanted pregnancies, and sexually transmitted diseases.”

With this awareness in mind, it has become imperative for reproductive health programs to work across the whole social context of women's lives to address gender-based health problems. (RHO, http://www.rho.org/html/fpp_overview.html)

In regards to young women however: *“while substantial investment has been made in recent years in adolescent programs, recent reviews indicate that many do not address gender inequalities, include girls or attend to their specific needs such as reaching out-of-school adolescents. Often programs take a narrow, vertical approach tailored to specific health concerns (early pregnancy, for example), without considering adolescents’ educational, economic, and other social needs.”* (IWHC, <http://www.iwhc.org/index.cfm?fuseaction=page&pageID=21>)

Gender-sensitive services recognize that:

- Social concerns, including violence against women, poverty, female genital mutilation/cutting, commercial sex, and mental health issues harm women’s health;
- Many women have little control over their sexual lives and contraceptive choices;
- Women have a right to a satisfying, as well as a safe, sex life; and
- Women's health needs change over the course of the life cycle and extend beyond fertility issues.
- Providing opportunities for women to participate in planning, delivery and evaluation of services, and make changes accordingly improves service outcomes. (Barnett, 1998; Bruce, 1992, cited at http://www.rho.org/html/gsh_overview.htm#Gendersensitive)
- Changing provider attitudes is fundamental to delivering services sensitive to gender issues and to redressing gender biases. Common biases include assumptions that all service users are women, discomfort in serving clients of the opposite sex, and gender inequities in the professional relationships between staff members.

International Planned Parenthood Federation, Western Hemisphere Region, Inc. has developed a manual to assist staff in adopting a proactive gender perspective into its operations, identifying areas for improvement, and to strengthen staff's ability to critically analyze their own performance from a gender perspective. (Op Cit) Providers also need to address sexuality issues as an integral part of reproductive health. Practitioners have a special opportunity to provide information, education, and counseling to clients who otherwise might not have access to sexual health education and counseling. (SIECUS, <http://www.siecus.org/pubs/cnct/cnct0000.html>)

Kelts et al, (2001) examined the performance of American primary care physicians in providing sexuality and sexual health information to adolescents. They found that a high proportion of physicians, nearly 80%, reported discussing sexual health issues with adolescent patients but fewer reported addressing more sensitive issues such as sexual orientation or providing counselling. Female physicians were more comfortable in managing adolescent sexual health issues, and were more comprehensive in their provision of reproductive health information and preventative services. Younger physicians and those with a better working knowledge of standards of practice were also more consistent in their service to young people. (Kelts et al, 2001)

European Responses to Young People's Sexual Health

According to Berne and Huberman, (1999) "Rights, Responsibilities and Respect" is the social philosophy of adolescent S&R health in the Netherlands, Germany and France. High quality, accurate information and access to confidential S&R health services are viewed by government and society as a right of youth. This philosophy is dependent on societal openness, plus acceptance and understanding of youth as sexual beings. More time is spent on health promotion and educating youth about safe sexual behaviour, as well as empowering youth to take control of their sexuality and practice safe sex, as opposed to simply trying to prevent sexual behaviour. This attitude does not appear to promote promiscuity rather youth in these countries commence sexual activity up to two years later than their American counterparts. The result is that the Netherlands' teenage birth rate is eight times less than that in the United States and the gonorrhoea rate in Germany is 25 times less than the US rate. All three of the countries analysed place high value on ethical decision making and encourage youth to act ethically when making decisions about their sexual behaviour. The individual responsibility placed on youth thus encourages a united society that ensures there are appropriate services and information available to youth to support their choices.

In recent years the British government has taken a proactive stance on reducing the rising rates of both teenage pregnancies, sexually transmitted diseases, such as Chlamydial infection, and to improve sexual health services. The UK has one of the highest teenage pregnancy rates in all of Europe. (Maddern, 1998) Interestingly, Australia's rates are far higher than those of the U.K. In 1999, a national strategy was launched in the U.K. for sexual health and HIV, accompanied by a national safer sex information campaign. (White, 2001) The strategy focused on developing a model of integrated care, including:

- piloting "one-stop-shops" for young people
- improving access to information on sexual health, particularly for vulnerable groups
- attempting to redress the inequities in current service provision and
- requiring services to meet new standards on access, advertising, and signposting of service provision, and that all primary care trusts develop a single point of access to services by 2006.

A campaign to prevent teenage pregnancy was also launched aimed to reduce the rising rates. Key approaches of this strategy included:

- Targeting high risk areas.
- Educating young men about their responsibilities
- Improving sex education by including the realities of teen parenting and unprotected sex and
- Improving access to effective contraceptive services (Ferriman, 1999)

This breaks from the historical approach which has kept sexual health services as specialist services, by integrating them into general health and social policies. (Maddern,

1998) As part of the same effort, in 2001, the Glasgow National Health Scheme trust approved the first time initiative of providing family planning services in a pharmacy in order to improve access. (Kirwin, 2001)

Involvement of Men in Sexual and Reproductive Health Services

A key priority of the ICPD Programme of Action (paragraph 7.14) is:

“To increase the participation and sharing of responsibility of men in the actual practice of family planning.”

(WHO, http://www.who.int/reproductive-health/hrp/plan_of_work/fplanning.en.html)

The Alan Guttmacher Institute (AGI), a non-profit U.S. based research group, has also recommended that policymakers and the medical community involve men in sexual and reproductive health in a concerted effort to improve public health and reduce the high rates of STDs and unintended pregnancies.

(<http://www.kmrp.org/pages/n0204over.html>)

In a report ***Young Men’s Sexual and Reproductive Health: Towards a National Strategy***, which culminated from a think tank of American experts, it was proposed that emphasis should be on men in their early 20’s who, according to evidence, tend to be more sexually active and engage in higher risk taking behaviours, such as not using condoms. This report maintained that young men generally lack access to S&R health care due to having different health seeking behaviours. Moreover, family planning clinics have traditionally not been welcoming and have not tailored services to meet young men’s needs. The propensity for clustering of risk taking in young males, including unprotected sexual activity, substance abuse, and violence makes it difficult to create a single issue focused model. A vision for young men’s sexual health is presented with five key platforms to achieve it:

1. Promote sexual health and development
2. Healthy Intimate relationships
3. STD/HIV Prevention and Control
4. Unintended Pregnancy Prevention
5. Responsible Fatherhood

It is envisaged that successful outcomes will be achieved through provision of education, including skill building, counseling, clinical and support services, to promote healthy social development. Community partnerships are needed to provide an integrated response and serve hard to reach, at risk young men. Priority groups identified were young men of colour, those in their early 20’s, from disadvantaged backgrounds, in the criminal justice system, in foster care, out of school or who are same sex attracted. Establishing pilot programs may be advisable in a resource scare environment.

(http://www.urban.org/UploadedPDF/young_mens_health.pdf)

Watt, (2001) also observed that most pregnancy prevention programs focus on young women; and few effective or innovative programs exist for adolescent males. There is also evidence that there are gender differences with regard to sexual knowledge, attitudes, and behaviors and that young men lag behind their female peers. Such gender differences must be counteracted through development of more inclusive pregnancy prevention interventions. The Health Belief Model has been used effectively in interventions that actively involve adolescent males in the responsibilities of pregnancy prevention. Brindis et al, (1998) suggested that in co-counseling male partners on

contraceptive use, providers *"must take into account young men's sexual and contraceptive histories, but screening should go beyond traditional family planning techniques to discuss how to improve communication with partners and other lifestyle issues that may interfere with consistent use."*

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United Nations Population Fund,
http://www.unfpa.org/icpd/round&meetings/ny_adolescent/reportrt1.htm

The Center for Reproductive Law and Policy http://www.crlp.org/ww_iss_adolesc.html

Alan Guttmacher Institute, http://www.agi-usa.org/pubs/fb_teens.html

International Women's Health Coalition
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Inclen Research International Clinical Epidemiology Network.
<http://www.inclen.org/research/ah.html>

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<http://www.who.int/child-adolescent-health/ashr.htm>

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International Planned Parenthood Federation, Western Hemisphere Region, Inc. (IPPF/WHR). **[Manual to Evaluate Quality of Care from a Gender Perspective](#)**. New York: IPPF/WHR (January 2000). (Available online at www.ippfwhr.org/resources/QCGPtoc.htm.)

This manual is designed to help reproductive health organizations evaluate how thoroughly a gender perspective has been incorporated into its operations, to identify areas for improvement, and to strengthen staff's ability to critically analyze their own performance from a gender perspective. The manual discusses how to assemble an evaluation team, how to select a sample and implement the six instruments provided (clinic observation, observation of client reception, observation of consultation, client exit interview, service provider interview, and document review), how to analyze the results, and how to develop a plan of action. The instruments measure quality indicators in the areas of: institutional policies and practices, provider practices, convenience to client, client satisfaction, use of gender-sensitive language, IEC, and monitoring and evaluation.

Smith, J. and Colvin, C. **[Getting to Scale in Young Adult Reproductive Health Programs](#)**. Washington, D.C.: FOCUS on Young Adults, Tool Series 3 (April 2000). (Available online at www.pathfind.org/guides-tools.htm.)

This tool outlines key steps to help program planners and managers institutionalize and expand effective adolescent reproductive health programs. The tool explains how programs can achieve greater impact in terms of increasing the numbers of young people served, broadening the geographic coverage, and, sometimes, expanding mandates. It outlines key concepts, describes program experiences with scaling up, explains lessons learned, and includes tools to help program planners and managers to scale up their efforts.

Sharma, R. **[An Introduction to Advocacy: Training Guide](#)**. *Academy for Educational Development*. Washington, D.C.: AED (1998). (The publication can be ordered from www.aed.org/pubs_democ.html).

This guide is designed for program managers, researchers, professional institutions, and others who are interested in bringing about program or policy change. The guide provides tools to help them better understand advocacy, build basic advocacy skills, access and use data to inform the advocacy process, and become involved in shaping health policies and programs. The guide is written primarily for use in training sessions, but it also can be used by potential advocates as a tool to help them start their own advocacy work.

International Conference on Population and Development (ICPD). **[Programme of Action](#)**. (1994). This is the online version of the Programme of Action from the International Conference on Population and Development, Cairo, 1994. For sections relating to rights of adolescents see ICPD Principles 4, 9, 10, and 11, and Chapter 5.

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International federation of planned pregnancy-youth friendly checklist for S&R clinics <http://www.ippfwhr.org/resources/youthchecklist.pdf>

The use of participatory approaches, the importance of addressing factors in the social environment, and the need to focus on the development of positive social skills as well as the prevention of problems. The report's central chapters assess the effectiveness of

five major groups of interventions identified as crucial to adolescent health and development: creating a safe and supportive environment, providing information, building skills, offering counseling, and making health services attractive and accessible.

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