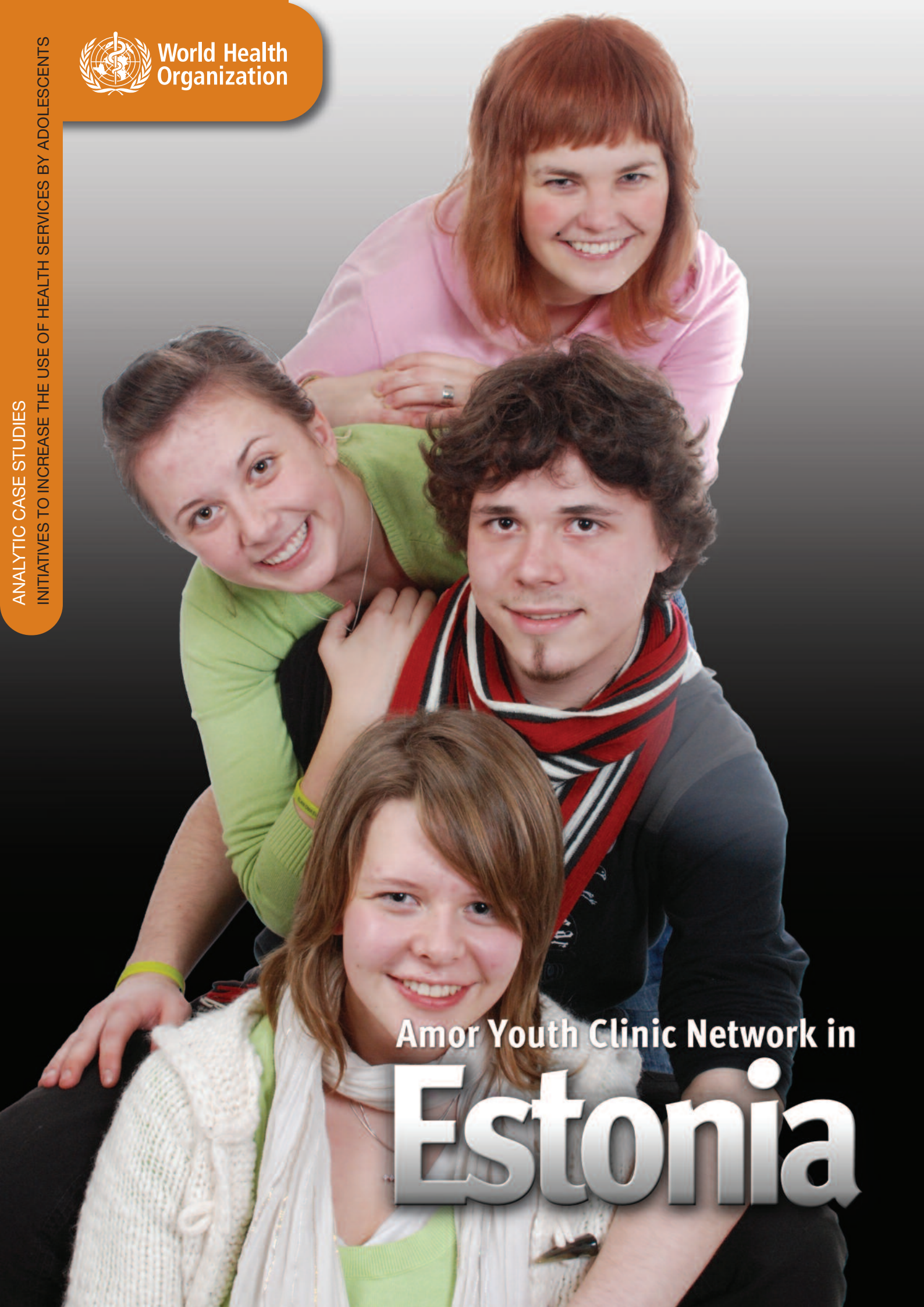
World Health Organization

ANALYTIC CASE STUDIES

INITIATIVES TO INCREASE THE USE OF HEALTH SERVICES BY ADOLESCENTS



# Amor Youth Clinic Network in Estonia

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**Kai Part and Tiia Pertel,** Editors

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*Volunteers of ESHA and counsellors of youth counselling center by Valijana Brok*

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# Contents

# Foreword

Though many individuals and institutions have important contributions to make to the health and development of adolescents, health workers play a particularly important role. As health service providers, they need to help adolescents maintain good health as they develop into adults, through the provision of information, advice and preventive health services. They also need to help ill adolescents get back to good health, by diagnosing health problems, detecting problem behaviours and managing these when they arise.

Unfortunately, for a variety of reasons, adolescents are often unable to obtain the health services they need. In many places, health services, such as emergency contraception, are not available to anyone, either adolescents or adults. In other places, where these health services are available, adolescents may be unable to use them because of restrictive laws and policies (e.g. laws that forbid the provision of contraceptives to unmarried adolescents) or because of the way in which they are delivered (e.g. the cost of health services is beyond their reach). Even where adolescents are able to obtain the health services they need, they may be discouraged from doing so because of the way they are delivered. Common reasons for this include fear that health workers will ask them difficult questions, put them through unpleasant procedures, or scold them; or that health workers will not maintain confidentiality. Finally, health services may be 'friendly' to some adolescents, such as those from wealthy families, but may be decidedly 'unfriendly' to others, such as those living and working on the streets. Not surprisingly, in many parts of the world, adolescents are reluctant to seek help from health facilities. If they do seek help, they often leave discontented and unhappy with the way they were dealt with; determined not to go back, if they can help it.

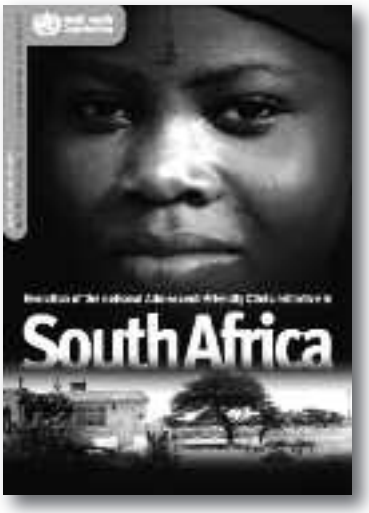
There is widespread recognition of the need to overcome these barriers and make it easier for adolescents to obtain the health services they need. Initiatives are being undertaken in many countries to help ensure that:

- health service providers are non-judgemental and considerate in their dealings with adolescents, and that they have the competencies needed to deliver the right health services in the right ways;
- health facilities are equipped to provide adolescents with the health services they need, and are appealing and 'friendly' to adolescents;
- adolescents are aware of where they can obtain the health services they need, and are both able and willing to do so;
- community members are aware of the health service needs of different groups of adolescents, and support their provision.

Nongovernmental organizations are in the forefront of these efforts in most places, although in a growing number of countries, government-run health facilities are also reorienting themselves in order to reach out to adolescents.

There is growing evidence of the effectiveness of some of these initiatives in improving the way health services are provided and increasing their utilization by adolescents. In the past, most of these initiatives were small in scale and of limited duration, however there are a growing number of initiatives that have moved beyond the pilot stage to scale up their operations across an entire district, province or country.

In 2006, the World Health Organization (WHO) department of Child and Adolescent Health and Development (CAH) published a systematic review of the effectiveness of interventions to improve the use of health services by adolescents in developing countries[1]. This review identified 12 initiatives that demonstrated clear evidence of the increase in the use of health services by adolescents. When presenting the findings of the review to policy-makers and programme managers in countries, WHO was pressed for information that went beyond the brief descriptions of interventions provided in the review, to more detailed information about what was being done in these different settings to scale up the provision of health services while maintaining and improving their quality.




In response, CAH has supported the documentation of three outstanding initiatives in different developing country settings. These are intended to provide analytic case studies of what has been achieved, to assist: i) governmental and nongovernmental organizations in developing countries that are involved in scaling up adolescent-friendly health services; and ii) staff members in international organizations that provide technical and financial support for these services.


WHO is pleased to share these three case studies from Estonia, Mozambique and South Africa. The key message emanating from each is that scaling up the provision of health services to adolescents in developing countries in a sustainable way is clearly doable, but it requires deliberate and concerted efforts.

[1] Review of the evidence for interventions to increase young people's use of health services in developing countries. Geneva, World Health Organization, 2006 (Technical Report Series, No. 938:151–204).

## ACRONYMS AND ABBREVIATIONS

| | |
|---|---|
| AIDS | acquired immunodeficiency syndrome |
| EFPA | Estonian Family Planning Association |
| EHIF | Estonian Health Insurance Fund |
| ESHA | Estonian Sexual Health Association (before 2005 EFPA) |
| HIV | human immunodeficiency virus |
| IPPF | International Planned Parenthood Federation |
| NGO | nongovernmental organization |
| STI | sexually transmitted infection |
| WHO | World Health Organization |

# 1. Background

## Demographic and socioeconomic situation in Estonia

**Major socioeconomic changes have taken place in Estonia since it regained independence in 1991. These include the establishment of a democratic parliament; replacement of the planned economy with a market economy; implementation of health care reforms and establishment of a health insurance fund that receives 13% of every employee's wages; availability of all modern contraceptives; and inclusion of sex education in the school curriculum. In 2004, Estonia became a member of the European Union.**

As of 2007, the population of Estonia was 1 341 672 – 46% male and 54% female. Young people* aged 15–24 years made up 15.3% (205 395) of the population, of which 51% were males and 49% were females. According to the past two censuses (1989 and 2000), the Estonian population has decreased by 12.5% due to negative natural growth and migration. In 2007, 69% of the Estonian population lived in urban areas and 31% in rural areas; 69% were of Estonian nationality, 26% Russian and 5% belonged to other nationalities[1].

Estonia's unemployment rate has been decreasing steadily since 1995, and was 4.7% in 2007. The unemployment rate of non-ethnic Estonians is approximately twice as high as that of ethnic Estonians, and is even higher among young people[2].

Estonia has a relatively high level of general education. According to studies, the literacy rate is 99%. In 1999, 88% of the population aged 25–59 years had completed secondary school education. Every year about 1000 students (0.57%) drop out of school in Estonia[2].

In 2007, 96% of the Estonian population was covered by health insurance. The law stipulates that all those aged 19 years and below are automatically covered by health insurance. Estonian health insurance is a social insurance that covers the costs of health services provided to insured persons, pays for prevention and treatment of diseases, finances the purchase of medicinal products and medicinal technical aids, and provides such benefits as assistance to persons who are temporarily incapacitated and therefore unable to work[3].

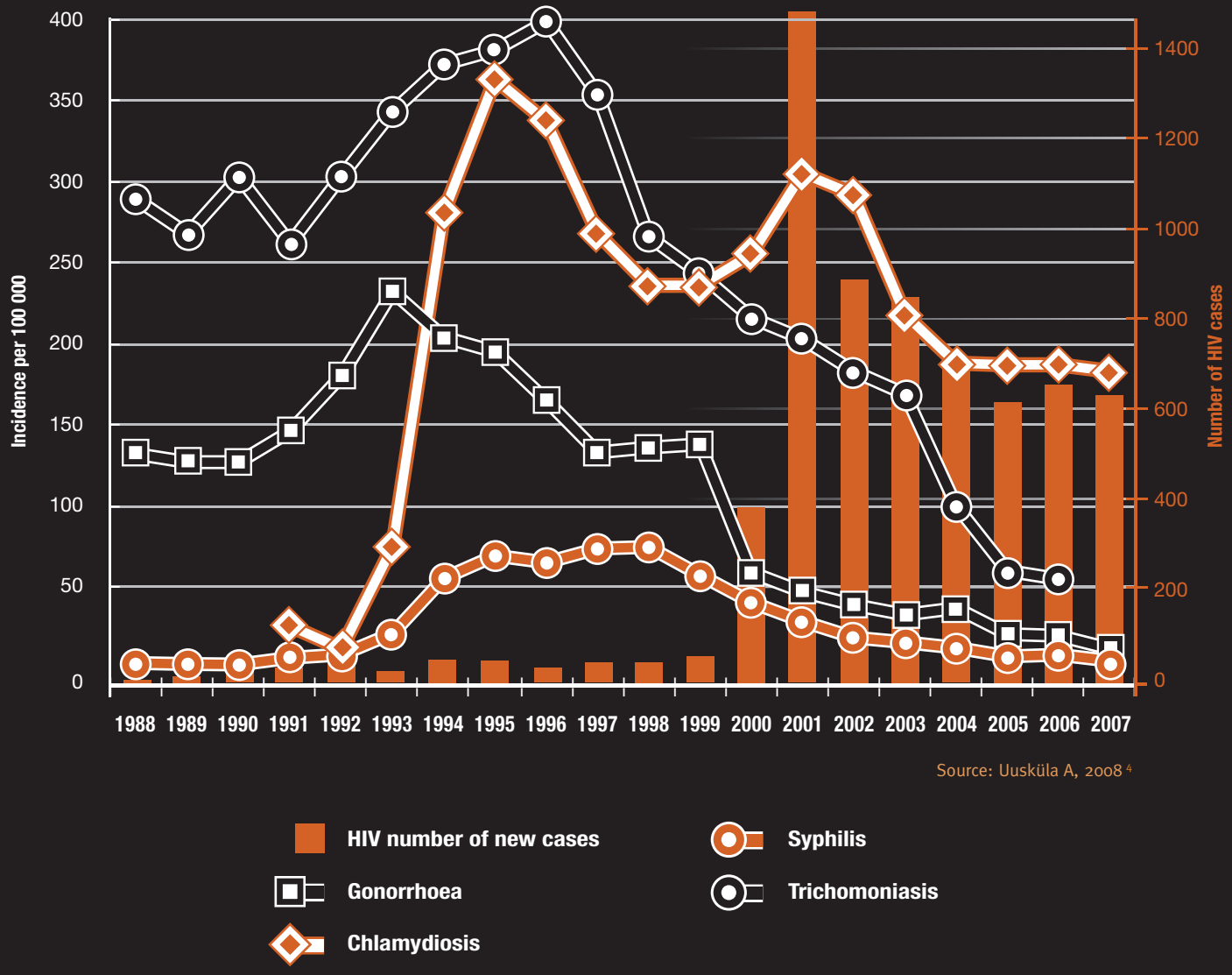
## Sexual and reproductive health of young people

### *Prevalence of human immunodeficiency virus (HIV) and sexually transmitted infections (STIs)*

The prevalence of STIs increased abruptly in the 1990s. However, since 2000 there has been a decrease in the incidence of traditional STIs (syphilis and gonorrhoea), while the prevalence of chlamydia and viral STIs (herpes and papilloma virus) remains high. STI incidence data is based on Health Protection Inspectorate statistics (Figure 1)[4] and may not reflect the actual situation since Estonia does not have an infectious diseases register.

* WHO defines "young people" as individuals aged 10¬–24 years, and "youth" as individuals aged 15–24 years. In this document however, the terms "youth" and "young people" are used interchangeably to denote those in the age group 15–24 years.

*Figure 1.* ***Incidence of HIV and STIs per 100 000 people in Estonia, 1988–2007***




Source: Uusküla A, 2008 [4]

In 2000, the HIV epidemic began spreading in north-eastern Estonia among injecting drug users. This area of Estonia has the largest non-ethnic Estonian population and highest unemployment rate. The seriousness of the situation in Estonia becomes apparent when it is compared with that in other countries. In 2002, Estonia had 1080 new cases per 1 million residents while Finland, Latvia and the Russian Federation had 25, 342 and 597, respectively. In 2005, Estonia had 467 new cases while Finland, Latvia and the Russian Federation had 26, 130 and 247, respectively [5]. By the end 2007, 6364 cases of HIV were registered in Estonia but according to experts the actual figures may have been 1.5 to 2 times as high. Young people accounted for almost 40% of newly registered cases in 2007 [4].

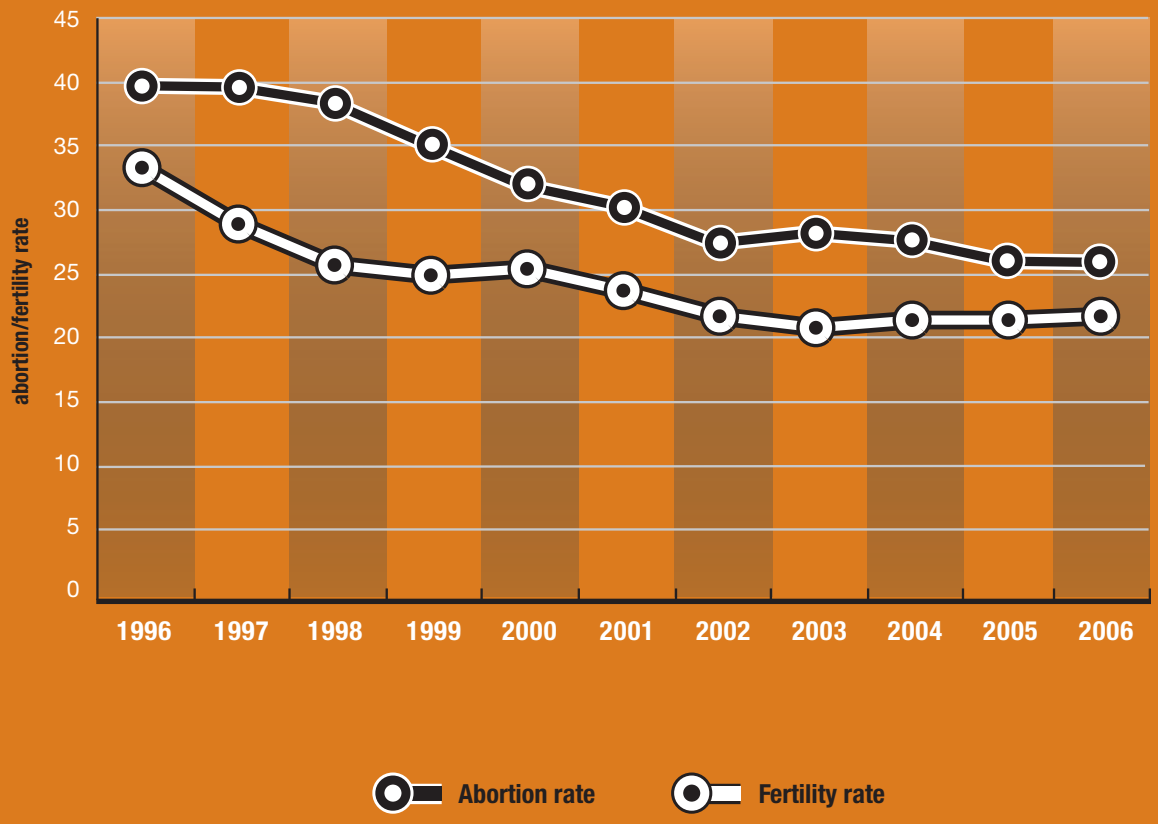
Surveys showed that in 2004 there were approximately 13 800 injecting drug users among the adult (15–44 years) population of Estonia [6], with an estimated 62%, or nearly two-thirds, living with HIV. Of those surveyed, 84% were male, 56% were under 25 years of age, and 82% were ethnic Russians [7].

## *Teenage pregnancies*

During the past decade there has been a decrease in the abortion rate in Estonia among all age groups, including teenagers. In 1996, the rate of legally induced abortions per 1000 15–19-year-old females was 43; in 2006 this had dropped to 26. The abortion rates among 20–24-year-old females during the same years were 92.8 and 44.8, respectively[8]. The number of teenagers giving birth has also declined. In 1996, the fertility rate per 1000 15–19-year-old females was 36, which had decreased to 21.8 by 2006 (Figure 2)[9]. Although remarkably decreased, the number of teenage pregnancies in Estonia is still higher than in Finland where, for example, in 2003 the abortion rate among 15–19-year-old females was 15.2 and fertility rate was 10.4[10].

The proportion of teenagers among the total number of women giving birth has declined. In 1992, teenagers accounted for 14.6% of the total number of women giving birth, in 2001 teenagers accounted for 9.8% and in 2004 7.8%. This percentage remains higher than in Finland where in 2000 it was under 2.9%[9,10,12].

*Figure 2.* ***Number of abortions and births per 1000 15–19-year-old females in Estonia, 1996–2006*** [8,9,11]



### *Age at first sexual intercourse*

The age at first sexual intercourse in Estonia has declined over the past decades. A study in 2000 showed that the age at first sexual intercourse for women born during the period 1927–1931 was 22.3 years while that for women born during 1977–1980 was 16.4 years. The corresponding figures for men were 19.7 and 16.2 years, respectively [13]. A survey in 2005 showed that 45.6% of all 16–18-year-olds, 87.7% of all 19–24-year-olds and 97.1% of all 25–29-year-olds of both sexes had had sexual intercourse. The average age at first sexual intercourse for men as well as women was 17.5 years [14].

### *Contraception use at first sexual intercourse*

While there is little research regarding contraception use among young people, it is known that contraception use at first sexual intercourse among students finishing compulsory education (15–16-year-olds) did not increase between 1994 and 1999. The majority of 9th grade students participating in a school-based study, who had experienced sexual intercourse and used some contraceptive method, had used condoms; very few had used pills or post-coital contraception during the study period (1994–1999) [15]. Condom use at first sexual intercourse among youth increased from 46% in 2003 to 62% in 2005 [14].

### *Sexual awareness*

An increase in sexual awareness among young people has been noticeable since the mid-1990s. The proportion of students with good sexual awareness in the last classes of compulsory education was 43.4% in 1994 and 62.1% in 1999 [15]. The improvement in sexual awareness continued into the 2000s. In 2003, 18% of all young people surveyed were aware of the HIV transmission routes, and by 2005 this had increased to 36%. In 2003, 44% of youth answered all five tested questions regarding the prevention of STIs correctly, while in 2005 51% answered these questions correctly. The knowledge of young people concerning specific questions was considerably higher – for instance, 90% of young people were aware that condom use during every sexual intercourse decreased the risk of HIV transmission [14].

## Organization of sexual health education and health care

During the Soviet period (i.e. pre-1991), sexual and reproductive health issues were primarily the responsibility of gynaecologists and midwives. One objective of reforms in the health care system in the 1990s was to entrust family doctors with full responsibility for sexual and reproductive health. However, this was not achieved and gynaecologists, midwives and specialists continued to deal with issues of prevention, diagnosis and treatment in this area.

Disease prevention in Estonia is managed through various public health programmes. In 1999, the Ministry of Social Affairs asked the Estonian Sexual Health Association (ESHA) to develop a national programme for reproductive health (called "National Programme of Reproductive Health, 2001–2009") which was approved by the government in 2000. However, financing was not provided for its implementation. Parts of the programme, such as sexual and reproductive health counselling services for young people, received financing as separate projects from the Estonian Health Insurance Fund (EHIF) in 2002.

In 2004, the EHIF instituted five long-term priorities for health promotion and disease prevention. One of these was to promote activities for the healthy development of children. This included school health care, a project for the prevention of hereditary disease and early detection of congenital metabolic disease, and the youth reproductive health counselling and STI prevention project which received financing for the medical activities of Amor* youth clinics [3].

The prevention and treatment of HIV and STIs on a national level have been carried out mostly through public health programmes. The "Estonian National HIV and AIDS Strategy, 2006–2015" was developed in 2005 with the collaboration of representatives from government ministries, local government, nongovernmental organizations (NGOs), the private sector and other interest groups. One of the three priorities of the strategy is prevention activities among young people – including sexual health education and counselling.

In 1996 the school curricula incorporated a new compulsory subject, beginning from the fourth grade, called "human studies". This subject included courses in health, relationships, psychology and family. The new subject has established that, besides knowledge and skills, the development of attitudes is important in sexual education in schools. In 2002, the number of mandatory human studies lessons in schools was reduced, but the goal of the subject remained the same, i.e. to promote human integrity, healthy development and responsible sexual behaviour.

In Estonia, since the end of 2003 post-coital contraception has been available at pharmacies without a prescription, and since 2004 it has been possible to obtain a six-monthly prescription for hormonal contraceptive methods (pills, transdermal systems and vaginal rings), instead of the earlier two-monthly period. Today, most modern contraceptives are available in Estonia.

The NGO sector has had a significant role in the development of sexual and reproductive health legislation, education and services. In 1990, a group of volunteers (doctors, scientists, teachers, youth workers) founded the Estonian Association Anti-AIDS. Activities of the association included voicing concerns related to sexual behaviour risks in the mass media, compiling literature, organizing sexual educational group work for students and young people on military service, and acquainting teachers with sexual education methods. The Estonian Family Planning Association (EFPA renamed ESHA in 2005) was founded in 1994 and provided leadership for the establishment of youth clinics across Estonia in the 1990s, to fill the gaps between national sexual health care and education activities. Other organizations dealing with sexual education in Estonia include the Estonian Academic Society of Sexology, Society of Human Studies, Estonian Red Cross, and the NGO Living for Tomorrow [16].

* Amor youth clinics are youth-friendly free-of-charge sexual and reproductive health clinics in Estonia, where both males and females are welcome. The clinics are specially designed to address the sexual and reproductive health needs of young people. The clinics provide not only advice concerning contraception and testing for HIV/STIs, but also a chance to talk about relationships and sexuality with a professional. These clinics are meant exclusively for young people, though if they are part of a larger clinic then certain hours are dedicated to young people.

# 2. Youth clinics: the early days and how the network developed

## Youth counselling – how it began

### *Recollections of Helle Karro, gynaecologist, ESHA President 1994–2000*

**By 1993, only a few years after Estonia had re-established its independence, family planning and contraceptive use had not changed much since the Soviet period. The birth rate rose with the move to independence but began to decline soon afterwards. The abortion rate, however, remained very high. In 1992, there were 143.3 abortions for every 100 live births and close to 70 induced abortions for every 1000 females of fertile age. Abortion was often used as a family planning method. Despite modern contraceptives being available, few women used hormonal contraceptives. Instead, intrauterine devices and less reliable methods such as coitus interruptus and the calendar method were more commonly used. Family studies were a part of the school curriculum but varied greatly in content and quality, and actual sexual education was lacking.**

In view of this situation, we planned a programme called "From Abortion to Contraception". The project was organized and coordinated by the World Health Organization (WHO) Regional Office for Europe and initially financed by the Swedish International Development Agency. At first the project was supposed to include two target groups: "abortion group" (pre- and post-abortion counselling) and "postnatal group" (counselling and contraception use following childbirth). These two groups were chosen because the number of repeat abortions in Estonia was very high, as was the number of unwanted pregnancies followed by childbirth. The objective was to increase the availability of contraceptives, improve counselling and raise the awareness of the community and medical professionals.

During my work, I noticed that young females were not comfortable talking openly about their problems with a gynaecologist as they had encountered judgmental attitudes and disapproval in the past. Consequently, in Estonia gynaecologists were often approached to help solve problems rather than to prevent them. I was inspired by Sweden's health-care facilities that provided youth counselling through 250 youth clinics, and envisioned organizing something similar in Estonia. This resulted in the inclusion of a third target group "youth" in the project in 1993.

By this time a youth clinic (with separate reception times at the women's clinic) had been opened in Viljandi (a town in central Estonia). With the start of the project we decided to expand on this idea and obtained separate rooms for a clinic for youth in Tallinn (capital city of Estonia). After considering the options, we decided that it would be best to locate the clinic in a hospital to permit flexibility in the use of personnel and support services. Pelgulinna Hospital was supportive and I received their help in identifying appropriate rooms, making the necessary arrangements and finding funding for the renovation of rooms.

In 1993, contraceptive devices could be obtained only by purchasing them at full cost. Funding from the WHO project was used to distribute contraceptives (pills, condoms) free-of-charge, to compile and print the first information pamphlets, and to design a youth clinic logo. An important part of the project was the training of counsellors.

These were the beginnings of the youth clinic idea in Estonia. Over the years it has developed and thrived due to the enthusiastic and sincere work of the counsellors [17].

# The beginnings

## *Recollections of Malle Praks, gynaecologist and founder of the first youth clinic in Viljandi*

Youth counselling in Viljandi began in 1991 with the support of Sweden's Falun Borlänge Zonta Club. A delegation of women from Zonta visited Viljandi in 1990; among them was a pharmacist from Falun Hospital, Mrs Gerd Henriksson. On their visit to our hospital that day, Mrs Henriksson decided that a youth clinic was required when she saw a frightened 15-year-old girl who had come in for an abortion.

We visited Sweden and became acquainted with their youth clinics and the principles behind youth counselling – during a visit, only the counsellor is present with the teenager giving them a sense of security; the youth counsellors aim to give advice and not to impose their own opinions; and the reception area for young people is separate from that for adults. From Sweden, we returned with materials for seminars and counselling, and with condoms, pregnancy tests and several suitcases of pills. In 1991, we began a youth clinic two nights a week with a gynaecologist and a midwife. We were full of enthusiasm and willingness to work. A psychologist joined us in 1993. The number of clients has multiplied over the past 10 years.

It is wonderful that there is a network of youth clinics in Estonia, which the ESHA helped to establish [17]. We are known and trusted and our first patients have already given birth to their first children.

## *Recollections of Made Laanpere, gynaecologist, founder of the third youth clinic*

The ESHA and the Viljandi and Pelgulinna Hospital youth clinics were founded in 1994. The ESHA had proclaimed that addressing youth was the priority for its activities. At this time, while a large selection of contraceptive methods was already available, use was often hindered by myths and misconceptions. Gynaecologists were unaware of how much they could do to help women with their choices.

The chief doctor at the Tartu Women's Clinic understood the need for such a service, especially in a city where the target group, because of the presence of the University of Tartu, was large, educated and receptive. She also understood that an idea without funding would not be viable. She suggested that, as a young gynaecologist, I should set up a youth clinic in Tartu. The idea was realized in 1995 in a room of 25 square metres at the Tartu City Health Clinic. The Karlstadt Zonta Club provided the start-up funding, which was invaluable since we were able to provide independent rooms and fulfil right from the start that necessary requirement for a youth clinic, i.e. confidentiality. We also received aid from the Tartu City Government and the Ministry of Social Affairs.

Enthusiasts had to be found for volunteering at the clinic, as financing was still unclear. Our first co-workers were from my circle of friends. Since then more people have been

interested in working at the clinic and it has been a starting point for several gynaecology residents.

In the beginning we started with sexual education lectures at schools and then individual counselling. Visitors started coming immediately and news about us spread by word of mouth. At first we did not know what types of problems to expect. In addition to counselling, we organized seminars for health care officials, teachers and doctors. We repeatedly had to convince officials who thought our clinic dealt only with sex.

Today, there is great satisfaction because we were able to create a strong and unified team and there has been consistent development in everything we have undertaken[17].

# How the ESHA helped to create the youth clinic network

***Recollections of Kai Haldre, gynaecologist, ESHA, executive director 1994–2001***

## Priority – youth

The ESHA, founded in 1994 with the support of the International Planned Parenthood Federation (IPPF), is an IPPF European Region member. In the early 1990s the biggest problem, as seen by the ESHA, was the high rate of abortions and low use of contraceptives. The prevalence of STIs had increased dramatically. The lack of information and double standards of the previous decades influenced our efforts in promoting awareness in family planning, and sexual and reproductive health. Estonia lacked practice in sexual education and people-friendly counselling. Health promotion that was oriented to youth and based on human rights became the priority of the ESHA.

## Training for youth counsellors

The first youth clinics in Estonia began their activities before the founding of the EFPA/ESHA. Several founders of these youth clinics were also among the founders of the ESHA and went on to form the core of the organization. The idea to create a network of ideologically unified youth clinics, with the ongoing training of workers, resulted from one of the first training sessions and was followed by the determination of common interests and planning of new courses. Training courses for youth counsellors were free of charge. As a member of the IPPF, we had close contacts with our colleagues in Finland, Netherlands, Norway and Sweden. The opportunity to use lecturers from other countries and organize a series of training courses in the 1990s was in many ways groundbreaking. Personally, I found the courses unforgettable since many issues were discussed which had not been talked about before or had been mentioned only superficially. Thinking back, many colleagues have found that these courses provided them with great personal and professional motivation and greatly affected their values and attitudes.

Some of the important training topics in 1995–2000 were: sexuality, sexual development, sexual anatomy and physiology; teenage sexuality, school sexual education, teenage counselling services; compilation of sexual health teaching materials, sexual violence and counselling, drug addiction, disability and sexuality, teenage patients, counselling in cases of pregnancy termination, and counselling psychology.

## Mutual support and cooperation

The ESHA supported, within its means, the activities of all the youth clinics. Within the framework of the World Bank's Estonia Health Project, several clinics were able to purchase necessary educational equipment such as video players, televisions, boards, copy machines. The local youth clinics became an extension of the ESHA outside of Tallinn, creating a network among the local governments, schools, teachers and medical workers.

The courses in continuing education, organized two or three times a year by the ESHA, became important occasions for the exchange of information and strengthening of team spirit. Journalists within the ESHA wrote about the events in various publications. In turn, involvement with the youth clinics inspired the ESHA to put together sexual education teaching and information materials. The materials were circulated both in the youth clinics and to other medical and educational institutions across Estonia. Insight into sexual education from the youth clinics helped to shape ESHA health education projects for school teachers and school medical workers.

Irregular funding was the major concern of all the youth clinics in the 1990s. Financing was dependent on the goodwill of local officials as well as successful lobbying by staff members to obtain project funds. Financing was needed for both medical services and educational activities. As a result, during 1996–1998 the ESHA took its first steps towards obtaining regular funding from the government. At that time the requests were denied. In 2001, a new application was made to the EHIF and we received funding for a five-year prevention project. The ESHA was responsible for the use of the funding in each of the youth clinics.

The idea of promoting and unifying quality of care came from the youth clinic staff members, and was possible to achieve due to government funding. The approval of common funding was the result of years of hard work by the youth clinic staff members. With the past years of experience, the ESHA is now able to begin the organized training of staff members/counsellors for new clinics.

## Lessons learned from creating and developing a youth clinic network

- The 10 years of experience in creating and developing Estonian youth clinics has shown that good ideas should be boldly expressed, even if at first they seem unrealizable.
- It is necessary to define precisely both the objectives and the means and rules for achieving them even in an unofficial association formed by enthusiasts. This ensures that the process is democratic and is necessary both for further development and to receive further funding.
- It is important to learn from the positive experiences of other countries. Visits to other countries and visits by lecturers from them can give further impetus and inspiration for improving the local situation. At the same time, all good examples cannot be implemented without considering the local circumstances. For example, the most important person in Swedish youth clinics is a midwife. However, in Estonia midwives were not sufficiently qualified to work independently at the beginning of the 1990s, and therefore the gynaecologists had to take on this responsibility. However, the situation has been changing during recent years and midwives have been taking on more responsibilities.
- It is extremely important to cooperate with key local figures and organizations, and not to rely only on foreign professionals and donors to achieve further support and sustainability for the youth clinics.

# 3. Amor youth clinics

## Why, for whom, where?

### *Why?*

Adolescence is a time of changes. The body develops, there is a need for independence, friends become more important, adolescents fall in love and form sexual relationships. A search for an identity is central at this age and young people search for answers to vital questions such as "Who am I?", "What am I like?", "Will I find somebody to love?".

This time of change can be confusing, involving excitement as well as doubt and failure. Often in the quest for independence, young people take unreasonable risks and encounter situations that are difficult for them to handle alone. They are an easily influenced target group for the values imposed by advertisers and the mass media.

Many questions arise with the discovery of sexual identity, as does the need for information and support. Despite seemingly abundant stores of knowledge, it is not easy for young people to find reliable information – talking to parents about sexuality is uncomfortable, they are unsure of their peers' advice, information on the Internet is often of a pornographic nature – creating more confusion and conflicting feelings. Sexual education in schools has progressed but is still not uniform and is often problem-centred. Approaching a women's clinic or family doctor with their problems may be frightening for young people, as they are emotionally unprepared.

Young people are more likely to visit a youth clinic because they know it is specifically intended for them and employs youth-friendly methods. Those coming to the clinic for the first time come trusting the recommendations of their peers and return after a positive experience. It is of great importance that the service remains free of charge and is readily available.

### *For whom?*

The youth clinics in Estonia are intended for young people of both sexes up to the age of 25 years. There is no minimum age. Twenty-five years is the maximum age limit since most Estonians at that age have completed their education (university), are starting work, are more mature as individuals, informed of their rights, getting along better in society, and more aware of health care services. Youth clinics help young people make choices in their lives at an age when they need the most support, encouragement and help.

Unfortunately, it is difficult to provide equal access to sexual health counselling and education for all young people. There are several groups whose needs have not been met and different ways to reach them have been developed. For example, youth living in rural areas have more difficulties in reaching clinics. This was one reason for the initiation of an online counselling service through the Amor youth clinic web site (www.amor.ee) and publication of a series of articles called "ABC to Love". Another reason is that Internet use among young people is very popular.

Youth clinics are open to both young males and females; nevertheless there are considerably fewer visits by young males. As a result several clinics provide separate hours for counselling for boys and young men, as well as specific printed materials for them. To improve access to counselling and information for non-ethnic Estonians, a youth counselling web site and online counselling service are available in Russian. Specific training is available for specialists working

with mentally and physically challenged young people. Since 2007, the government has financed services for young people of 19 years and older who do not have health insurance. The needs of school drop-outs, young drug users, and young homosexuals are still not fully met in the youth clinics. Identifying ways to reach these young people is an important task in the near future.

*Figure 3.* ***Location of Amor youth clinics in Estonia, 2008***


## Where?

The first clinic was established in Viljandi in 1991, followed by clinics in Tallinn, Tartu and later other locations across Estonia. Currently there are 18 youth clinics in 14 counties (Figure 3) that offer services in the following ways: through departments within larger health institutions (9 clinics), as free-of-charge services for young people at private gynaecological practices (7 clinics), or as private practices set up especially for this service (2 clinics).

The amount of work and number of staff members varies between these youth clinics. Most of the clinics are exclusively for young people, and open every

workday with several specialists being available. Smaller clinics may open only during certain hours – once or twice a week specially for young people. Most of the medical staff members in Estonia are female, but in six out of 18 clinics there are a few male professionals (mostly doctors).

For many years the youth clinics looked for a suitable name. In Estonian, the clinics are labelled by their direct translation, "youth counselling centres". The word counselling has created some confusion among the public since there are also psychological and crisis counselling centres meant for the entire population. Also, the word "counselling" does not indicate the medical as well as sexual health counselling services provided by the youth clinics. Over the past years open youth centres have been created as places for young people to spend their free time, furthering the confusion and also creating the need for a clear and catchy name. For the above-mentioned reasons the name "Amor youth clinics" was chosen in 2002. Today, in 2007, it has yet to become a brand among young people and they use their own short forms for the clinics. Hopefully, the youth clinics through their activities and quality service will be more widely known and adults will no longer need explanations about these establishments.

## Working principles

All youth clinics work according to common principles for the promotion of the sexual health of young people. The main principles are to help young people to accept their sexuality, to recognize their needs and rights, and to provide trustworthy information and counselling.

All youth clinic staff members receive the same general training and preparation for work with young people. Young people must feel secure, welcome and respected in the clinics. Services are free for both sexes up to the age of 25 years and visits are voluntary.

Working principles involve an integrated approach to problems, providing counselling in medical, psychological as well as social matters. Ideally, clinic specialists (doctor, midwife, nurse, social worker, psychologist) work together as a team (Table 1). The services for young people complement each other to form a whole. The smaller clinics, where all the above-mentioned specialists are not available, cooperate with specialists outside the clinic who are working in the same area.

*Table 1.* **Specialties of youth counsellors working at Estonian youth clinics and clinic work week schedules for 2007**

| YOUTH CLINIC | Start of youth counselling | Clinic youth counsellor specialties | Clinic work week (hours per day) |
|---|---|---|---|
| West Tallinn Central Hospital youth clinic | 1993 | ■ gynaecologist<br>■ midwife<br>■ counsellor for young males<br>■ psychologist<br>■ social worker | 8 hours, 5 days per week |
| East Tallinn Central Hospital youth clinic | 1998 | ■ gynaecologist<br>■ midwife<br>■ counsellor for young males | 8 hours, 5 days per week |
| Sexual Health Clinic youth clinic | 2004 | ■ gynaecologist<br>■ counsellor for young males | 3 hours, 2 days per week |
| Pärnu youth clinic | 1996 | ■ gynaecologist<br>■ midwife<br>■ psychologist | 3–8 hours, 5 days per week |
| Rapla youth clinic | 2001 | ■ gynaecologist | 2–4 hours, 4 days per week |
| Haapsalu youth clinic | 1993 | ■ gynaecologist<br>■ midwife<br>■ psychologist | 2 hours, 1 day a week |
| Kuressaare youth clinic | 1996 | ■ gynaecologist<br>■ midwife<br>■ counsellor for young males<br>■ psychologist | 3 hours, 5 days per week |
| Tartu youth clinic | 1995 | ■ gynaecologist<br>■ midwife<br>■ nurse<br>■ counsellor for young males<br>■ social work<br>■ teacher | 7 hours, 5 days per week |
| Viljandi youth clinic | 1993 | ■ gynaecologist<br>■ midwife<br>■ counsellor for young males | 2–5 hours, 4 days per week |
| Elva youth clinic | 1996 | ■ gynaecologist<br>■ midwife | 1–2 hours, 3 days per week |
| Põlva youth clinic | 1997 | ■ dermato-venerologist | 1–4 hours, 3 days per week |
| Jõgeva youth clinic | 2005 | ■ gynaecologist | 3 hours, 2 days per week |
| Võru youth clinic | 1996 | ■ gynaecologist | 2 hours, 1 day a week |
| Ida-Viru youth clinic | 1996 | ■ gynaecologist<br>■ midwife<br>■ counsellor for young males | 5 hours, 5 days per week |
| Rakvere youth clinic | 2005 | ■ gynaecologist<br>■ midwife-social worker<br>■ psychologist | 2 hours, 1 day a week |
| Paide youth clinic | 1994 | ■ gynaecologist | 2 hours, 1 day a week |
| Narva youth clinic | 2000 | ■ gynaecologist<br>■ midwife<br>■ psychologist | 3 hours 5 days per week |
| Valga youth clinic | 2007 | ■ gynaecologist<br>■ midwife | 4 hours, 2 days per week |

To encourage visits, the atmosphere at the clinics is friendly and informal with a work routine that supports privacy. It has been kept in mind that youth clinics should be located in places accessible to young people, preferably separate from other health care establishments, and that the clinics should offer privacy, open at regular hours suited to young people, and give them the opportunity to visit alone, in pairs or in groups.

# Services provided

The main services offered by the youth clinics are of equal importance and include medical and psychological counselling (see above) and sexual education lectures for students. Medical and psychological counselling (i.e. contraceptive counselling, STI testing and management, HIV testing and counselling, pre-abortion and post-abortion counselling, gynaecological and urological examination, sexual counselling, psychological counselling and counselling after sexual violence) is financed by the EHIF. Local governments or short-term projects finance sexual education lectures. In addition to the primary services listed above, telephone and online counselling are also provided. The detailed description and statistics of services are presented below.

## *Medical and psychological counselling*

The objectives of counselling are to offer information, improve a young person's self-evaluation skills and offer support in making individual decisions. Counselling is available for individuals as well as couples. Medical services available along with counselling include STI testing (for syphilis; polymerase chain reaction test for chlamydia, gonorrhoea, genital herpes, papilloma virus and trichomoniasis) and management, HIV testing, pregnancy tests and contraception counselling. In cases of unprotected intercourse, counselling about post-coital contraception (emergency pills are available over the counter) and further contraception is provided. In cases of unwanted pregnancy, the clinics offer pre-abortion and post-abortion counselling as well as the necessary tests and referral for abortion. Gynaecological and urological examination is offered and recommended by the staff members once every 12 to 18 months for those who are sexually active. Persons can come in for examination during drop-in hours without registration if they have acute symptoms or have recently had unprotected intercourse.

Psychological counselling provides answers to questions regarding development (puberty, physical and relationship changes), intimate relationships and sexual problems, sexual identity and questions about starting sexual intercourse. In cases of sexual violence, basic crisis counselling as well as medical and psychological aid is available.

Prescribing (hormonal) contraception requires in-depth discussions, where the staff members aim to ascertain clients' contraception needs, try to inform them about possible contraindications and health hazards, and offer thorough information about the selected method to ensure better compliance. Waiting periods for repeat contraception prescriptions are kept as short as possible – in most clinics repeat prescriptions for contraceptive pills can be obtained on the same or next day. When prescribing repeat contraception, the staff members offer additional information, if needed, discuss possible side–effects, and clients are reminded of the need for medical check-ups. For clients involved in risky behaviours, testing for STIs is verbally recommended and the nearest possible appointment (not more than two weeks) for examination and STI testing is offered.

## Sexual education

Lectures and group discussions at the youth clinics provide students with information and the opportunity to discuss their sexuality and close relationships. These lectures are effective supplements to school sexual education classes. Schools, of course, have a more important role: curriculum classes are structured to broadly cover the topics of personal relationships, friends, love, sexual experiences and gender roles. However, schools generally cover topics that are easily taught in a lecture format (STIs/HIV, puberty, contraceptive methods) and sexual topics are presented more in terms of the dangers and problems. Topics requiring an individual viewpoint or discussions (such as masturbation, sexual minorities, personal relationships) are less often approached [15]. This is where youth clinics can help.

At the time when youth clinics began their activities, school sexual education programmes varied considerably. Therefore, during a lecture by clinic staff as many topics as possible were covered. It soon became apparent that this was not feasible or necessary. Today, while a topic is agreed upon beforehand with the teacher, it can be redirected during the lecture according to the interests and questions of the students. Where possible, lecturers use interactive methods, such as group work, discussions and games.

Through lectures, students become acquainted with the clinics, their methods and staff members, which is an objective in itself, thus helping to reduce possible barriers for visiting a clinic. Once young people have visited a youth clinic and are assured of its friendliness, they are more likely to return for advice and help in the future.

## Telephone counselling

Telephone counselling has been added to the list of services as a special individual activity. Work is organized according to the size of the clinic and availability of staff members. At most clinics young people can call at specified hours to ask for advice or register a time for a visit, if needed. In a few of the larger clinics the phone counsellor has no other duties at that time. In this way, calls to the clinic do not interrupt the other everyday activities and if need be, allow the counsellor to talk to the caller at length. Telephone counselling can help solve a problem without a visit to the clinic, reducing the number of unnecessary visits and waiting times.

## Online counselling

The Tartu Youth Clinic initiated online counselling with aid from the Open Estonia Foundation in 1998. A series of articles about sexuality, contraceptive devices and safe sex were compiled with the help of young people and displayed on the Amor homepage. The first web site was “home-made” but soon became popular among young people. Today, the original web page has grown into the ESHA web page (www.amor.ee), which includes the Amor Internet youth counselling portal. A team of 30 specialists, most of whom work at youth clinics, answer queries received by email.

Online counselling saves time, both for those needing help and for specialists. Through the Internet a counsellor can gain the trust of young people, help solve crisis situations and refer them to a youth clinic or specialist. The Internet is accessible to most people in Estonia, including young people in rural areas and disabled people, whose access to professional help is usually limited.

At present 3000–4000 e-mails are received per year. Of the correspondents, approximately 80% are female and 20% male. The administrator distributes letters to suitable respondents. Letters are answered within a week (usually three days). The correspondent remains anonymous and receives a personalized answer via e-mail. The administrator keeps track of the answering rate, has an overview of the respondents' workload and tries to prevent delays in answering.

Online counselling is managed by the ESHA and a workgroup has been created to further develop the service. Since 2003, the EHIF has financed online counselling. The development of the quality of online counselling and its evaluation is in progress: standards of quality for online counselling and a description of services have been compiled; supervision and discussions are carried out; and every year, two staff members evaluate and report on the e-mail responses given by the staff members through random correspondence checks. The web site has added a new component – a "forum" for discussions. Development of the web site through additional articles (in the "ABC to Love" series) and a "frequently asked questions" page help to limit the number of repeat enquiries. Estonian language materials are currently being translated into Russian.

## *Counselling for young males*

Even though youth clinics are intended for young people of both sexes, the majority of clients are female. Young males account for only 4–5% of the visitors. However, in the past few years the interest of young men in the clinic has grown and accounted for 12% of first-time clinic visitors and 20% of Amor online counselling clients in 2006.

The first clinic to provide separate hours for young men was established in 1999. Presently seven clinics out of 18 provide separate visiting hours for young men. Males visit the clinic usually on the referral of a specialist or their partners' suggestion, and less on their own initiative or on the suggestion of their friends. The main reason for clinic visits is STI testing, but clients also come with questions and problems concerning their body and development, becoming sexually active, sexual identity and sexual activity.

Developing services to reach young men has been hampered by two factors – the lack of male sexual health specialists in Estonia, and because young men in Estonia generally visit doctors less often. Youth clinics try to support visits by young males by organizing additional training courses and directives for the existing male counsellors, compiling a pamphlet in Estonian as well as Russian ("Suggestions for young males"), distributing a flyer about visiting hours and publishing articles on the Internet. The Swedish Association for Sexuality Education and ESHA organized training visits and courses for specific training of counsellors for young males, as it is unavailable in Estonia. This, as well as practical work, has been very useful.

# Lessons learned from providing services

- A distinctive feature of youth clinics in comparison to traditional health systems is their use of integrated medical and psychological counselling services.
- Services must be accessible and adapted to the needs of young people – provide services free-of-charge, make available specific written information materials, maintain short waiting lists, and keep separate youth-friendly rooms. It is extremely important that a youth counsellor is always "on the same wave length" as the young person; judgmental and condescending attitudes generate distrust and fear and convince young people never to visit a clinic again.
- Equal emphasis must be laid on medical and psychological counselling, and sexual education lectures. By attending lectures, young people get used to the clinic and are apparently more willing to come for a personal visit when needed. Therefore, offering sexual education lectures is a pre-condition for increasing the number of visitors to the clinic.
- Young men in Estonia visit youth clinics less often than do young women. This must be taken into consideration while planning a clinic, advertising the service, training the staff members and setting up the function of rooms. There is a need to increase awareness among young men and get them to visit the youth clinic.

- Young people are as diverse as their needs and not all may be able or ready to visit a clinic. It is beneficial, if the opportunity exists, to offer them alternative sexual health information and counselling options, such as through telephone and online counselling. The rapid development of information technology and its popularity and availability among young people in Estonia has enabled the initiation of an appealing online counselling service which has significantly increased the effectiveness of activities of the youth clinics.

- The creation of new services or networks for young people should begin with ideas of how to clearly differentiate youth clinics from other similar organizations. An understandable name together with a clearly distinctive image helps gain popularity among young people.

# 4. Quality of care

## Expansion of activities and measurement of quality

### *Government financing – opportunity to promote quality of care*

**The staff members of the leading youth clinics emphasised the need for quality control as they felt that the "youth clinic" must comply with measurable standards to justify the name. The EHIF wanted to prevent the rising incidence of HIV and was interested in a unified network of youth clinics with a strong management to form a trustworthy partnership. The idea behind the establishment of a network of youth clinics was that clinic visitors in the various regions across Estonia should have access to the same services at each clinic and that the services should be uniform and of good quality.**

Since 2002, the EHIF has financed medical activities of the youth clinics as part of a five-year project, thus providing an impetus for expansion and improvement of quality. The project named "The Project for Reproductive Health Counselling and STD Prevention in Young People for 2002 to 2006" was started with regular fundings. Regular financing enabled the clinics, for the first time, to think about management in the long term that would support project objectives and further development of youth clinics. Several fundamental documents were developed, as were agreements on future directions and work principles. The long-term aims of the project were to reduce the number of legally induced abortions among young people by 25% and the incidence of STIs by 10%. Long-term financing enabled the establishment of the following objectives for 2002–2006: improved accessibility to youth clinic services, preservation and promotion of quality counselling (shown by satisfaction of young people with services), increased use of services (especially by first-time visitors and young males), and increased awareness of young people of sexual health issues thus promoting more responsible sexual behaviour.

Regular financing continued in 2007 as a part of the "National HIV and AIDS Strategy for the years 2006–2015" and the financing of services (medical and psychological counselling, online counselling) continues through the EHIF.

### *Youth clinic quality requirements and working principles*

For Estonians to have access to uniform and quality services at each clinic necessitated the discussion and compilation of quality requirements describing the principles of youth counselling and stipulations for their observance.

The development of quality requirements for all youth clinics was unique in that the initiative came from the staff members of the leading clinics and ESHA board members who voluntarily wanted to unify the quality standards. Being part of a network means expecting the same style and quality of work from others. Therefore, the quality requirements are always ensured in the establishment and support of new clinics, as well as in the assessment of existing ones.

The formal quality requirements differentiate the youth clinic network from other health-care service providers. The requirements are regularly amended according to the proposals from the clinics and acceptance of the network's group of volunteers. A short summary of the requirements for quality is given in Appendix 1.

## *Management and development activities*

Government financing allowed the ESHA to employ a part-time project manager in 2002 and to form a workgroup of volunteers with youth counselling experience. The workgroup has eight members; among them are a youth representative, youth clinic managers with long-term experience, and network initiators, as well as the previous and current project managers. The members include various specialists with long-term experience in youth counselling, sexual health and education. The workgroup plays an important part in the planning of activities, their implementation and evaluation of effectiveness. The ESHA makes an effort to involve clinic administrators in network development activities by organizing information days and through regular electronic correspondence. This gives the administrators a chance to give feedback and ideas concerning clinic operations. Clinic representatives are allowed to take part in workgroup meetings.

An important development activity is the initiation of new clinics, which occurs in two ways. Firstly, clinics are established through the support of the ESHA in regions and counties where there are none. The establishment of new clinics is based primarily on geographical need. Today there is only one county, with the smallest population, in Estonia where services are not available. Secondly, existing clinics – such as those who do not adhere to the basic youth counselling principles or new organizations that are able to provide a wider range of youth counselling services – may be reorganized.

The establishment of new clinics requires a lot of time and energy. Therefore, an attempt is made to involve a wide circle of decision-makers and influential groups (media, local authorities). Youth clinic work principles and quality requirements are followed in the initiation of a new clinic. New clinics need support and work instructions for start-up and ongoing activities. New clinic workers are provided with the opportunity of gaining practical experience at one of the well-established and successful clinics. To help direct clinic work, workgroup members visit the clinic frequently before it opens as well as afterwards to discuss with the staff members various issues regarding their actual work and organizational matters. Since clinic workers carry out the actual work, the final decisions regarding work organization are made by each clinic independently, with the workgroup offering suggestions and observing that youth counselling principles are followed.

Every year new young people needing sexual health information become a part of the target group. Many young people obtain information from the ESHA web site (www.amor.ee) as well as from new printed matter compiled every year, such as posters and flyers, appearances on television and radio, and articles published in newspapers and magazines. In addition, an attempt is made to participate in national as well as local youth-oriented events to distribute information in cooperation with other youth organizations and institutions[18].

## Participation in additional projects

The IPPF Quality of Care programme during 2003–2005 was one of the largest with the participation of 12 youth clinics. The objective of the project was to provide clinics with the skills for self-assessment. To promote quality of care, a strategy was developed whereby the service providers assessed themselves from the perspective of the clients and their rights (information, access, privacy, confidentiality, respect, safety, comfort, choice, continuity and dignity) and the needs of the service provider (training, information, infrastructure, guidance, supplies, backup, respect, encouragement, feedback and self-expression). The project also provided material aid.

As a network the youth clinics have also participated in several short-term projects, such as the IPPF-financed projects, within the framework of the European Union Daphne Programme which has a specific project to prevent and combat violence against children, young people and women and to protect victims and groups at risk.

## Continued and basic training for clinic staff members

The youth clinic network originated from the ESHA training courses in the 1990s. The training courses provided a place to make new contacts, exchange experiences and get support for establishing new clinics and sustaining existing ones. Two directions have been followed in the organization of training courses – one that provides additional in-service training and guidance to existing staff members and another that offers basic training in youth counselling to new workers.

By the early 2000s, several new staff members who had joined the youth clinics had not taken part in the ESHA training courses in the 1990s. These new staff members were professionals (doctor, midwife) but lacked specific preparation in the field of youth sexual and reproductive health. By this time the ESHA training centre, Amor, had been established, which had developed a study programme and in 2004 organized the first "Youth counsellor basic training course" for 20 youth clinic workers.

The course involved 160 hours of lectures and independent work and covered the following topics: sexual and reproductive health and rights, various aspects of sexuality and forms of expression, terms and words associated with sexuality, sexuality in the media, sexual orientation, sexual anatomy and physiology, counselling principles, adolescent patient issues (evaluation of changes at puberty, sexual development, examination of genitals, eating disorders, acne, physical strain in adolescence), contraception and counselling, unwanted pregnancy and counselling, STI/HIV testing and counselling, sexual violence and counselling, pornography, teenage drug use, structure of youth clinic services, sexual education (content and methods), as well as individual and practical work at youth clinics.

To date this course has been offered only once but will have to be repeated in the near future as once again new workers, who have not completed specific training for work in youth clinics, have joined the clinics.

Since 2002, continuing education courses dealing with youth counselling have been offered for gynaecologists in Tartu University's Obstetrics and Gynaecology programme and Tartu medical faculty's programmes for nurses and midwives. Basic study programmes do not cover this topic.

# Evaluation

Government financing was a significant motivator for the development of an evaluation system. Long-term as well as short-term objectives for activities (see "Expansion of activities and development of quality" section above), are regularly monitored, evaluated and, if necessary, adjusted. Today, action plans are based on the results of previous assessments (volume of services provided by clinics) or feedback from target groups, workgroups and clinics (e.g. content of training and work directives).

During the first year of government financing, the workgroup visited each of the clinics involved in the project to analyse their activities. The clinics were given feedback and recommendations for necessary changes, keeping in mind the common working principles and quality requirements. In the following years, evaluations were carried out foremost in clinics where there were problems, for example in following the code and/or fulfilling quality requirements. New clinics are supported with work directives and an evaluation of services is carried out at the end of their first year of activity.

Gathering statistics and obtaining other feedback have over the years been very important parts of the work. Youth clinics give an activity report to the ESHA every quarter, and the statistical indicators that are compiled give the workgroup a chance to analyse each clinic's activities. A joint report that is presented each quarter to the funding body (the EHIF) includes a summary of management activities and an overview of the volume of services provided by each clinic. Each clinic receives feedback in which its actual activities are compared with those projected, those of other clinics and the project objectives. For example, records are kept of the number of tests conducted and the number of patients they are conducted on. If a clinic provides a disproportionate number of tests or services it has to explain the situation (such as if in one period a clinic performed a relatively large number of ultrasound examinations while at another a relatively low number of specific tests, e.g. for chlamydia). Each clinic receives an overview of the network's activities[18].

To obtain feedback from young people, regular surveys are conducted to assess satisfaction. Since 2003 young people can continually provide feedback online at www.amor.ee. Feedback from both sources (surveys and online) is used for the development of activities for network and individual clinics.

## Lessons learned from the expansion of activities

- The development of each of the clinics, as well as the entire network, stems in large part from a grassroots concern that has greatly helped in the realization of many good ideas. In addition, it is very important to have written working principles and to ensure that all network members abide by them. This helps to distinguish these clinics from other health care institutions.
- More important than identifying funding is to find the right, dedicated people for the job. The main feature of youth clinics is the people who are motivated and love their job. This fact, together with an ongoing training system and in view of the needs of the youth clinics and their continuity, plays an important role in promoting quality of care.
- Evaluation is an important part of the ongoing learning process of the network. Constructive and regular feedback from all (clinics to the ESHA, young people to the ESHA and clinics, workgroup to clinics, funders to the ESHA as well as clinics) has provided great productive energy.
- Regular financing, both for services and development actions, allows for the sustainability of services and ensures the continuous promotion of quality.

# 5. Results and feedback

## Results 2002–2006

### *Data collection (see also Evaluation section above)*

**The systematic collection of statistical data reflecting the work of youth clinics began in 2002 with the start of government funding and the opportunity to employ a project manager and a workgroup.**

Data are collected every quarter, and year-end reports are submitted to the funding body. Work completed in the previous year and in the first quarter of the current year is the basis for the work-plans for the following year of each clinic, as well as the entire network. Since 2005, the workgroup has provided each clinic with quarterly feedback concerning its work and the realization of projected goals for the volume of service. The reports are used as a basis for application for additional financing that same year, as well as for planning the volume of services for the following year.

### *Youth clinic visitors*

The number of visitors to youth clinics has been increasing every year (Table 2), mainly because of the increase in clients at bigger clinics and to lesser extent, because of clients visiting newly opened clinics. The majority of the clients are female university students. An overview the number of youth clinic visits in 2006 by clinic is presented in Appendix 2.

*Table 2.* **Socio-demographic characteristics of Amor youth clinic visitors, 2002–2006**

| INDICATOR | | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|
| Number of prevention cases* | | 20 980 | 22 189 | 23 858 | 26 070 | 27 763 |
| Number of clinics | | 14 | 14 | 15 | 17 | 17 |
| Age (%) | <14 years old | 0% | 0% | 0% | 2% | 3% |
| | 15–19-year-olds | 53% | 45% | 43% | 39% | 39% |
| | 20–24-year-olds | 47% | 55% | 57% | 59% | 58% |
| Nationality (%) | Estonian | - | 78% | 77% | 82% | 78% |
| | Russian | - | 22% | 23% | 17% | 21% |
| | Other | - | | | 1% | 1% |
| Social status (%) | Student | - | 50% | 45% | 39% | 42% |
| | University student | - | 38% | 43% | 44% | 42% |
| | Employed | - | 10% | 10% | 14% | 13% |
| | Unemployed | - | 1% | 1% | 1% | 1% |
| | Housewife | - | 1% | 1% | 2% | 2% |

* The number of prevention cases is not equivalent to the number of visitors (the actual number of visitors is somewhat lower), but shows how many cases have been dealt with during a certain period. The number of visits is somewhat higher since a single case may require more than one visit. Hence, the total number of visits in 2006 shown in Appendix 2 is higher than the number of prevention cases in the corresponding year shown in Table 2.

In 2002, with the start of government financing for medical services, the following objectives were set out for the next five years for providing better access to services and further development of high quality counselling:

- "good" or "very good" satisfaction levels from 80% of the target group;
- an increase in the use of services to 26 000 prevention cases per year by 2006;
- an increase in the proportion of first-time visitors to 20%;
- an increase in the number of male visitors to at least 10%.

Table 3 shows, by year, the achievement of objectives of youth clinics. The number of prevention cases and the proportion of first-time visits have increased yearly. First-time visits are those clients coming to a youth clinic for an initial visit. Satisfaction with services has constantly been over 90%.

Though the total number of male visitors has increased, as a proportion the goal has not been achieved. With an increase in the total number of visitors each year, the goal of 10% young male clients is difficult to achieve particularly due to the limited visiting hours and number of staff members trained to deal with young males. At the same time, the proportion of young males among first-time visitors is higher, though lower among returning visitors.

To achieve the short-term objectives concerning young males, activities (such as promotion aimed at young males during sexual education seminars at clinics and through the help of female visitors, additional training courses for staff members, and work instructions regarding male youth counselling) have been directed towards this target group. In 2006, while the objectives concerning young males were reviewed, the low number of visits by young males was also influenced by several factors (such as the lack of qualified male sexual

*Table 3.* **Achievement of goals of the youth clinics, 2002–2006**

| INDICATOR | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Number of prevention cases | 20 980 | 22 189 | 23 858 | 26 070 | 27 763 |
| Proportion of first-time visits (%) | 30* | 17 | 18 | 21 | 26 |
| Visits by males % (N) | 3.9 (804) | 3.7 (817) | 4.0 (843) | 4.0 (1047) | 5.2 (1446) |
| Online feedback of client satisfaction about youth clinic "good" or "very good" (%)** (see also *Online surveys* in Chapter 5) | No data collected | 95 | 95 | 93 | 94 |

* The high proportion of first-time visitors is due to incorporation into a single network and single report system

** In the youth counselling part of the www.amor.ee web site, youth have the opportunity to give feedback about the work of the youth clinics

health specialists in Estonia, and the fact that males generally visit doctors less often), which are difficult for the network to control (see also *Counselling for young males* in Chapter 3).

## *Services provided during visits*

The medical services available at youth clinics are classified as follows:

- **STI prevention:** STI screening and/or prophylactic examination including necessary testing. Examination includes counselling, treatment if needed, and recommendation for the partner(s) to return for testing also. In 2006, 22 743 free condoms were distributed at lectures and counselling sessions.
- **Sexual and contraceptive counselling:** contraceptive, pre- and post-abortion counselling, counselling in cases of sexual violence, as well as psychological and/or psychosexual counselling.
- **Contraception follow-up:** repeat prescriptions for contraceptives. This is accompanied by an assessment of health risks, blood pressure readings and tests for the early detection of STIs. Reproductive health counselling and repeat prescriptions are preferably available without pre-registration. No free contraceptives (except condoms) are distributed in the clinics.

Over the years the proportion of cases related to STI prevention and counselling has increased while the number of visits concerning contraception follow-up have decreased (Table 4). It can be assumed that the number of follow-up visits related to contraception has gone down because of the six-monthly prescriptions for contraceptives (started in 2004) and the expansion of online and telephone counselling.

*Table 4.* **Amor youth clinic prevention cases according to services provided, 2002–2006, % of total visits**

| INDICATOR | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Number of prevention cases | 20 980 | 22 189 | 23 858 | 26 070 | 27 763 |
| Number of clinics | 14 | 14 | 15 | 17 | 17 |
| STI screening % (N) | 28% (5 892) | 30% (6 767) | 32% (7 736) | 34% (8 900) | 35% (9 692) |
| Sexual and contraceptive counselling % (N) | 30% (6 355) | 28% (6 308) | 37% (8 894) | 40% (10 466) | 39% (10 599) |
| Contraception follow-up % (N) | 41% (8 647) | 41% (9 114) | 30% (7 228) | 26% (6 704) | 26% (7 472) |

## *Sexual education lectures and telephone counselling*

The EHIF finances medical services at youth clinics but funding for sexual education lectures and telephone counselling must be obtained from municipal authorities or short-term projects, or carried out as volunteer work by clinic staff members.

The number of lectures and participants has remained stable over the years despite not being regularly funded, and clinics having had to find resources on their own (Table 5).

A relatively large part of youth counsellors' time is spent on telephone counselling which has grown in volume over the years, except in 2006 (Table 5). The main issues raised by young callers are problems concerning the use of contraceptive devices, emergency contraception and menstruation, among others.

*Table 5.* **Amor youth clinic sexual education lectures and telephone counselling, 2002–2006**

| | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|
| Sexual education lectures | 501 | 550 | 523 | 543 | 655 |
| Number of lecture participants | 6 604 | 7 950 | 8 143 | 7 792 | 8 988 |
| Number of callers for clinic telephone counselling | 6 991 | 6 230 | 8 379 | 12 754 | 10 601 |

## *Detection of STIs*

The incidence of all STIs among young people in Estonia decreased during 2002–2005 (2006 data unavailable; Table 6). While several factors are responsible for this decrease in incidence of STIs, one of the factors is definitely the work of the youth clinics.

STI testing at youth clinics shows a positive trend: the number of tests has increased over the past five years (as has the number of prevention cases), and the number of detected cases of STIs has decreased (Table 7). Youth clinics in Estonia diagnose approximately 30% of new cases of chlamydia and trichomoniasis, 15–30% of new cases of gonorrhoea, but only approximately 1% of new HIV cases.

The low HIV-detection rate at youth clinics (since Estonia has a very high rate of HIV infection) may be because the spread of HIV began among injecting drug users who as a rule do not acknowledge their need for help and therefore are not voluntary (youth clinic) visitors. The following years may show an increase in the frequency of HIV cases diagnosed at youth clinics since an increase in HIV through sexual transmission has been noted in Estonia.

*Table 6.* **Number of new cases of STIs and incidence per 100 000 young people in Estonia in 2002 and 2005***

| STI | | 2002 | 2005 |
|---|---|---|---|
| Syphilis | New cases (N) | 90 | 30 |
| | Incidence/ 100 000 | 45 | 14 |
| Gonorrhoea | New cases (N) | 241 | 106 |
| | Incidence/ 100 000 | 119 | 50 |
| Chlamydia | New cases (N) | 1 890 | 1 460 |
| | Incidence/ 100 000 | 935 | 695 |
| Trichomoniasis** | New cases (N) | 840 | 361 |
| | Incidence/ 100 000 | 416 | 174 |
| HIV | New cases (N) | 627 | 340 |
| | Incidence/ 100 000 | 310 | 162 |

* The numbers of registered new cases among young people were obtained from the Ministry of Social Affairs health statistics database at www.sm.ee. Calculation of registered STI cases per 100 000 young people is based on Estonian Statistical Office data as on January 1 www.stat.ee.

** The latest data for trichomoniasis originates from 2004, as the government no longer keeps a case register.

*Table 7.* **STI testing and detection at Amor youth clinics, 2002–2006**

| STI | INDICATOR | 2002 | 2003 | 2004 | 2005 | 2006 |
|---|---|---|---|---|---|---|
| Gonorrhoea | Number of tests | 2 342 | 2 451 | 3 045 | 3 852 | 3 802 |
| | Positive cases | 40 | 57 | 30 | 33 | 36 |
| | detection % | 1.7% | 2.3% | 1.0% | 0.9% | 0.9% |
| Chlamydia | Number of tests | 3 380 | 4 430 | 5 114 | 7 035 | 6673 |
| | Positive cases | 455 | 466 | 400 | 450 | 455 |
| | detection % | 13.5% | 10.5% | 7.8% | 6.4% | 6.8% |
| Syphilis | Number of tests | 555 | 703 | 866 | 1 197 | 1 222 |
| | Positive cases | 0 | 0 | 0 | 6 | 1 |
| | detection % | 0.0% | 0.0% | 0.0% | 0.5% | 0.1% |
| Trichomoniasis | Number of tests | 4 076 | 5 091 | 4 959 | 5 483 | 5 582 |
| | Positive cases | 163 | 230 | 249 | 191 | 116 |
| | detection % | 4.0% | 4.5% | 5.0% | 3.5% | 2.1% |
| HIV | Number of tests | 517 | 734 | 859 | 1 313 | 1 259 |
| | Positive cases | 9 | 5 | 5 | 7 | 2 |
| | detection % | 1.7% | 0.7% | 0.6% | 0.5% | 0.2% |

## Teenage pregnancies

According to the Estonian birth and abortion registry data there was a slow decline in teenage abortion and birth rates during 2002–2005. The number of legally induced abortions per 1000 females under 19 years in Estonia was 27.5 in 2002 and 26.1 in 2005, and in the same years the numbers of live births per 1000 females under 19 years were 21.8 and 21.5, respectively. Amor youth clinic referrals account for 13–16% of the total number of abortion cases of those under 25 years of age per year, while 7–12% of all registered pregnancies of those under 25 years of age are carried to full-term in Estonia.

## Visitor satisfaction

The first assessment of visitor satisfaction with youth clinic services initiated by the ESHA was carried out in 1996. Three clinics participated and 201 young people were surveyed. A second study was carried out at the end of 1999 and at the beginning of 2000 involving seven clinics and 556 young people. A third study, with the participation of 14 clinics and 770 young people, was carried out at the end of 2002.

## Who is a youth clinic visitor?

Clinic visitors are young people (15–24 years of age). The average age of visitors in 2002 was 18.3 years. The most frequent type of visitor is an 18–20-year-old Estonian female, single, living at home with parents, attending secondary school or a higher educational institution, visiting the clinic the first time on the recommendation of a friend and making return visits.

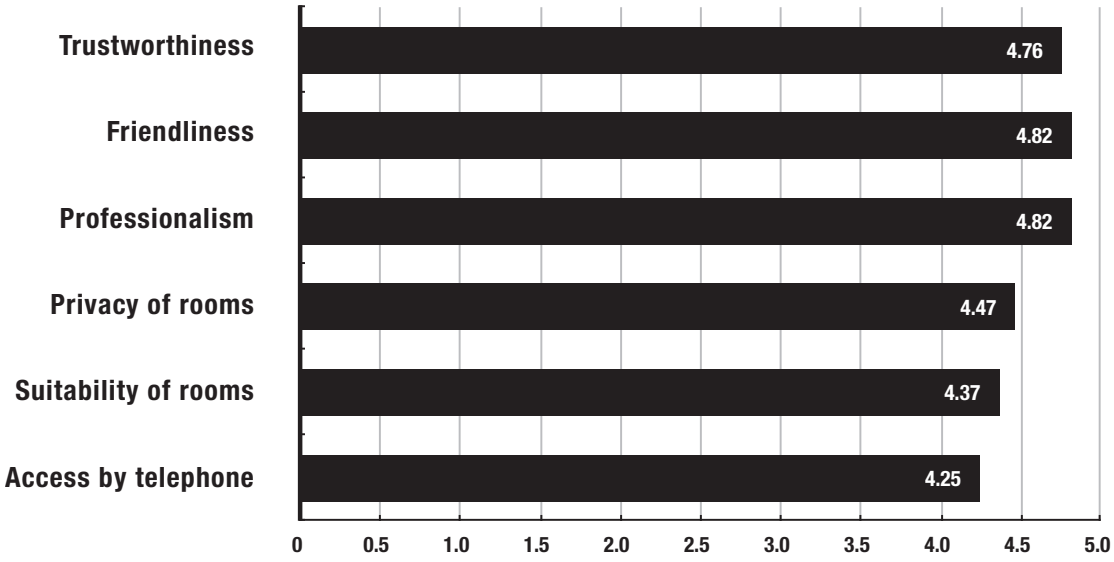
## Why do young people visit youth clinics?

Young people come to clinics to get advice on suitable birth control methods or physical (gynaecological) examinations, changes at puberty, concerns about becoming or being sexually active, STIs, unwanted pregnancies and in cases of sexual violence. The latest survey shows an increased interest in undergoing health examinations, especially STI testing.

## Young people's assessments of clinic staff members and clinic organization

The qualities most valued in clinic staff members were their friendliness and professionalism. Younger clinic visitors were more critical of and sensitive to the personal traits of staff members while older visitors were generally satisfied with clinic staff members. Respondents were more critical of the organization of services. They were least satisfied with the access to clinics by telephone, long waiting lists at some clinics and visiting hours that are unsuitable for young people and too short. Remarks were also made about limited space, and that intimate discussions taking place in the counselling room could be heard in the waiting room. The average ratings of various youth clinic services are presented in Figure 4.

*Figure 4.* ***Average ratings of the various aspects of clinics on a 5-point scale (1 lowest, 5 highest), 2002***




In general, clinic visitors are satisfied with the accessibility of services – reception is fast and uncomplicated. Visits to clinics are a positive experience as clients receive information that is not available at the school or home and find solutions to their problems. The most valuable thing for visitors was that these clinics are specifically intended for young people [19].

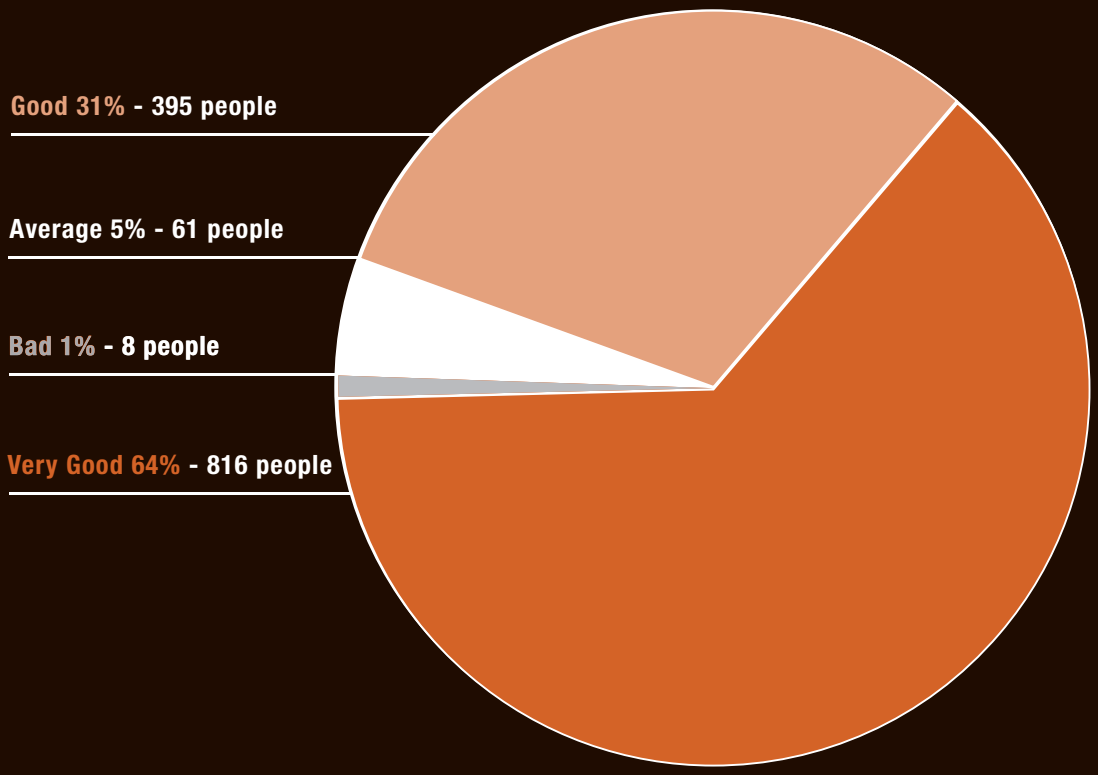
## *Online surveys*

In addition to the three surveys of visitor satisfaction, since 2003 clients have been able to voice their opinions through the ESHA web site (www.amor.ee). The active use of the Internet by young people prompted the idea of the online survey. A questionnaire was prepared and information regarding the opportunity to give feedback about clinic work was posted at each clinic in Estonian as well as in Russian.

Since the beginning of the survey in 2003 to the end of 2006, 1280 young people gave feedback online, of whom 95% rated the activities of the clinic as “good” or “very good” (Figure 5).

Online surveys give young people the opportunity to provide anonymous feedback to clinics concerning visits and the needs of visitors, and also to be a part of the development process of clinics. Online respondents are most satisfied with the clinic staff members – in particular, with their personal traits (friendliness, readiness to help, empathy), professionalism (ability to communicate, advise and explain) and their attitudes towards young people (tolerant, non-judgemental). Visitors also value the clinics’ organization (free services, short waiting lists in comparison to other options, telephone counselling). Young people added that they trust the clinic staff members and that clinics provide sufficient privacy and security.

*Figure 5.* ***Visitors' satisfaction with youth clinic services, online survey, 2003–2006***




Negative feedback has mostly been concerned with the lack of information regarding the youth clinics and the shortage of clinics and staff members. There have been complaints that clinics do not advertise themselves enough, that waiting times are too long, and that sometimes appointment times are behind schedule.

Online feedback cannot be and is not the primary source for the evaluation of youth clinic activities, although it is essential for young people to have the opportunity to give feedback about clinic work anonymously and at any time. The youth clinics consider this type of feedback to be essential so that they can respond promptly to any problems (organizational, youth counsellors) that may develop. There is concern that with online feedback it is not always possible to ascertain whether all respondents have actually visited a clinic and are giving their opinions of services they themselves received; however, presumably the majority are visitors since most evaluations are regarding a specific clinic. Obtaining online feedback has been relatively simple and does not require a lot of resources. It provides continuous, relevant and practical feedback through which many good ideas and stimulus to improve services are received [18].

Suggestions from young people have been important and have prompted significant changes at the clinics. Several ideas, which at first seemed implausible, have been realized. For example, for the past few years two of the larger clinics are using an online system for scheduling visits that takes into account the needs of both clients and clinics.

# 6. AMOR youth clinic: SWOT analysis

**The SWOT analysis of youth clinics is based on self-assessments of clinics and the clinic network undertaken at a summer training session in 2006, with the participation of youth counsellors from 11 clinics and most of the workgroup members.**

## Strengths

Our biggest strength is the *motivated staff members* in the clinics, the coordinating workgroup and the ESHA. Through the work and cooperation of all the interested parties and based on practical international experience the clinics developed and agreed upon common *youth-friendly principles* which each clinic adheres to. At the youth clinic, young people receive *versatile and integrated counselling and services* though various channels (counselling, lectures, telephone and online counselling). The network, with its grassroots beginnings, has been strengthened and its work secured by the *regular financing* of services as well as their coordination, which allows for *continuous and regular support and guidance* for staff members, including basic and continued training for those working with young people. Regular financing has also made it possible to carry out periodic *assessments of activities and services*, which help to sustain and promote quality of care. Youth clinics are *trusted and popular among young people*; accessibility to services is good and feedback from clients is positive – more than 90% of young people are satisfied with the services. When they were first established the youth clinics received *invaluable help from their Nordic neighbours* and still do today because of Estonia's geographic location and similar historical and cultural background.

## Weaknesses

One of the weaknesses of the clinic network is the *shortage of suitable staff members in specific fields* (e.g. Russian-speaking and English-speaking counsellors, counsellors for young males, and psychologists) and insufficient recruitment of new staff members, mainly at small clinics where work persists through the efforts of one or two people. The relatively stressful nature and increasing volume of work can lead to staff member *burn-out*. In some clinics that work as units of larger health care institutions, the *managers do not fully support* the codes developed for working with young people (resulting in problems, such as little privacy, lack of freedom to independently shape work management, and short visiting hours). Even though the exchange of information is intensive (in the form of information and training days, as well as electronically and by telephone), there is not always enough *exchange of information* (between clinics for example) regarding all the options available (e.g. referrals to specific specialists). The level of *cooperation* between local schools, social workers, parents and family doctors varies by district and requires a continuous effort but most clinics lack the human resources for this. The government has financed clinic medical services for the past five years while *sexual education activities* are still funded through short-term projects or are *insufficiently funded*.

# Opportunities

To provide a more versatile service for young people, one possibility is to engage, as youth counsellors, *social workers and psychologists* who have completed supplementary training (youth counsellor basic training course) and to *expand counselling for young males*. More information sessions could be organized at the clinics or short-term training courses for associated specialists (e.g. social workers, human studies teachers, school health workers) and a series of lectures could be developed for health care and social programmes at institutions of higher education. Widening of the clinic network to districts where either no corresponding service is available or limited service is offered is an important challenge and opportunity. Currently there is one county without a clinic and some clinics have very low visiting rates, such as in areas with a higher proportion of non-ethnic Estonians and where schools do not yet see the value of sexual education.

# Threats

One threat to the clinics is their *sustainability* if government financing is discontinued, since services intended for young people must not charge any fee. Government *financing is project-based* and there is a threat that project objectives could be altered by pressure from the funders rather than the long-term strategy plan of the clinics (e.g. financiers may pressurize clinics to increase STI testing and decrease counselling services). If regular government funding is not secured within the next few years for sexual education activities in the youth clinics there is the threat of a *decrease in the number of sexual education lectures*, which in turn will result in a decrease in the number of new clinic visitors. One of the concerns is that current funding for support services (e.g. online counselling) will be *discontinued*. Another serious threat is the *discontinuation of cooperation* from important local-level partners (e.g. as a result of a change of political office). Youth sexual and reproductive health is a long-term programme; however, with a new national health agenda, financing for services and/or their coordination could be discontinued.

# 7. Financing activities

**From the time the first youth clinic was established in 1991 until 2002, clinics depended on short-term projects for funds – usually foreign aid (e.g. staff members training through the Nordic Fund) or sporadic local or national government aid. During the 1990s, local governments lacked resources for health care promotion and were often unaware of the content of and need for youth clinic services. In one case a high-level local government official could not understand why "a girl needs to visit a youth clinic a second time if she's already been there once and became a woman".**

From the very start, youth clinic workers were convinced that services must be free of charge for young people. Along with the formation of the clinic network the search began for opportunities for consistent funding. The first applications for joint national funding made by the ESHA during 1996–1998 were not approved. The search for options continued along with efforts to influence key decision-makers. Funds allocated from the health insurance fund budget for disease prevention gave the youth clinics the opportunity to apply for financing of their services through the EHIF under the "Measures for Disease Prevention Action Plan" of the Ministry of Social Affairs. The clinics themselves submitted health promotion project applications to the health insurance fund each year, of which some were approved while others were not. The youth clinics applied and competed for financing along with all other health promotion projects. The number of project applications grew yearly, and the maximum were submitted in 2001. The evaluation of projects was based foremost on clear objectives, activities suitable to realizing the objectives, and the project's ability to assess activity results.

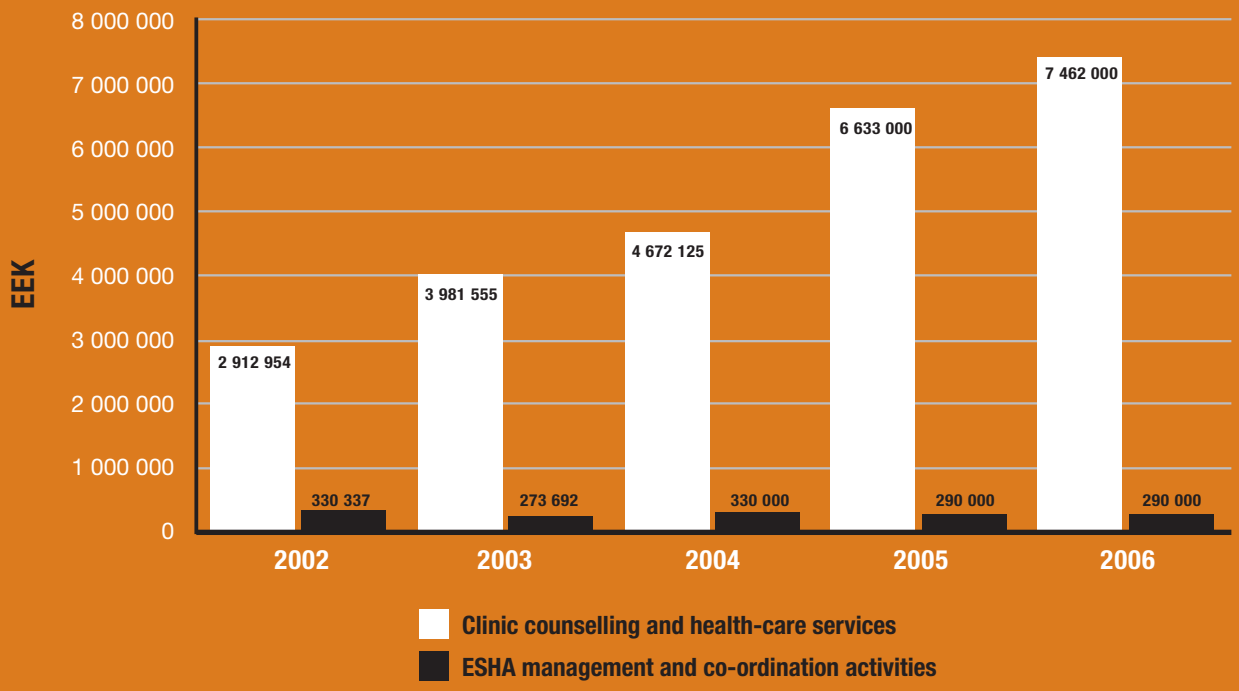
In 2000, the Estonian government approved the "National Programme of Reproductive Health, 2001–2009", which included sexual and reproductive health counselling, but it did not receive financing. The national programme prompted the ESHA to submit an application to the EHIF for the financing of youth clinic medical services as a prevention programme, called "The Project for Reproductive Health Counselling and STD Prevention in Young People for 2002 to 2006", which was approved for funding disease prevention as a long-term project. The project financed the medical activities of the youth clinics as well as the ESHA network management activities for the coordination of the network. Each clinic has a written agreement with the EHIF for the financing of medical activities, the volume of which is approved by the clinic network. Payment is based on the services provided and derived from the official register of health care services and the fee limits approved yearly by the government. Figure 6 below shows the project's projected budget by year. Increases in the budget are due to an increase in the number of prevention cases as well as an increase in the cost of services.

Sexual health lectures did not receive funding from the project, as they were not covered by the health insurance fund as a health care service.

In the past, sexual education activities were financed by the health insurance fund as single projects and more recently by the larger local government authorities, a few county administrations and private companies, but clinic lectures still lack common national funding. Several clinics conduct telephone counselling and the Tartu clinic, for example, has succeeded in obtaining funding for this service from the local government for several years. This has allowed this clinic to increase its volume of telephone counselling and conduct it separately from regular reception services. Other clinics provide this service at the same time as their regular reception.

Local governments, county administrations and various funds aid the majority of new clinics, during their establishment, financially or in other ways (e.g. advertising).

*Figure 6. Youth reproductive health counselling and sexually transmitted diseases prevention, 2002–2006 project financing (1 EEK=15.67 EUR)*




Youth clinics have been cautious in their approach to financing offered by pharmaceutical companies and hygienic product manufacturers, even though pressure from such companies has been immense. The youth clinics have adhered to the ESHA's policy of neutrality, under which monetary aid is not accepted from companies manufacturing birth control devices or hygiene products. This has ensured that clinic staff members have the independence that is necessary when giving clients advice about contraceptive methods and specific medications. However, samples of medications (including contraceptives) and personal hygiene products have been accepted according to procedures provided by law. The ESHA has also accepted aid from companies for the distribution of printed matter.

While the Open Estonia Foundation, EHIF, IPPF, United Nations Population Fund and the National Programme for HIV/AIDS Prevention have variously supported online counselling, since 2003 it has been financed by the EHIF.

## Lessons learned from youth clinic financing

- The enthusiasm and will of the clinic initiators to work will not last forever without systematic (national or local) funding. Also, applying for national funding is very time-consuming and applications for funding are required to be made repeatedly even after several successive refusals. It is very important to gain the support of the key figures involved with financing to ensure funding.
- Financing should be sought for clinics as service providers as a whole (centres providing comprehensive sexual education and counselling as well as health care services) and not as separate funding for each type of service. Also project-based financing should be avoided if possible since the realization of objectives and activities may involve pressure from funding agencies. In addition to the financing of medical services, it is just as important to find support for network coordination and development activities.

# 8. Summary and future plans

**The first youth clinics in Estonia were established at the beginning of the 1990s on account of the high rate of unwanted pregnancies and STIs among young people. The idea of youth clinics was inspired by the experience of Sweden. The first clinics began their activities without any regular funding but with enthusiasts and specialists who worked at the clinics in addition to their full-time work.**

A priority of the ESHA was the promotion of youth sexual health through sexual education and the promotion of youth counselling services because the roles of school and family in the promotion of sexual health were insufficient. The ESHA organized training sessions for youth counsellors (with teachers from Finland, the Netherlands and Sweden) and compiled sexual education literature. Local enthusiasts established youth clinics independently in various parts of Estonia but the ESHA soon became a unifying umbrella organization since several youth clinic staff members were also members of the ESHA. The ESHA has played a significant role in achieving the objectives that sustain youth clinics: preparing sexual education materials for schools and counsellors, providing online counselling, and setting up a sexual education web site (www.amor.ee). The creation of the ESHA and its promotional work prompted the establishment of new youth clinics in various regions across Estonia.

Over time it became apparent that the youth clinics needed regular long-term financing, without which it would be difficult to maintain the motivation to offer a stable quality of service. Several of the first attempts to secure funding failed, including applications to the "National Programme of Reproductive Health, 2001–2009". Continuous applications and efforts to influence key figures resulted in an approval of a five-year funding from the EHIF (approval of "The Project for Reproductive Health Counselling and STD Prevention in Young People for 2002 to 2006", providing funding for youth clinic medical services and clinic network management by the ESHA). The youth clinics have demonstrated the results of their activities, and therefore regular government financing has been assured from 2007 onwards. The youth clinics are a part of the "Estonian National HIV and AIDS Strategy, 2006 –2015" and these activities continue to be financed through the EHIF.

Financing for services as well as network management has considerably helped in the development of youth clinics, i.e. the formulation of universal principles, ongoing advertising, ongoing training of staff members, an assessment system and, most importantly, sustainability.

The development of clinics has been prompted mainly from the grassroots level. The process for the development of principles, systems for assessment and collection of statistics is democratic and transparent, and incorporates ideas and suggestions primarily from young people and their experiences with the youth clinics.

The biggest challenges have been the promotion and expansion of counselling services for young males, the establishment and development of new clinics (cooperation on a local level) and the management of clinics that do not adhere to the common principles. It has been difficult for the clinics, as well as the ESHA, to find regular financing for sexual

education seminars held at the clinics. Other challenges include the need to deal more actively with school dropouts, young drug users, young homosexuals and other population groups who are particularly at risk of HIV in Estonia.

## Future plans

Most important is an assurance of the quality and continuity of youth clinics in the future. The need for youth clinics will always remain but continuous hard work provides the opportunity to promote sexual health and safe behaviour among future generations of young people. The fight against the HIV epidemic is becoming more apparent at youth clinics with predictions of a higher rate of HIV infection through sexual contact and an increase in its detection at youth clinics. An increase in the proportion of young male youth clinic visitors and regular, basic and continued training of staff members are important objectives in progress. Youth clinic support of sexual education in schools is currently increasing in response to the reorganization of the curriculum, which threatens to decrease the number of sexual education classes. With 15 years of experience in the initiation of clinics and development of a network, Estonia can share its knowledge with other nations, and visits have already been made to Armenia, Belarus and Latvia to exchange experiences[18].

In 2007, there were 18 Amor youth clinics in Estonia (only one county had no clinic). In 2006, the clinics had dealt with 28 000 prevention cases. The WHO Regional Office for Europe advocates a minimum of one youth-friendly clinic offering sexual health counselling for every 100 000, 10–24-year-olds[21]. Estonia has at least one for every 35 000 persons in that age group. It can be said that the accessibility to sexual and reproductive health counselling services in Estonia is fairly good. Feedback from clients has been positive; the youth clinics are trusted and popular among young people. The number of unwanted pregnancies has declined remarkably over the past 10 years and contraception use has improved, clearly due to the work of the youth clinics.

In summary, the concept of youth counselling has developed successfully and taken hold due to years of enthusiastic and sincere work by counsellors supported and sustained by government financing.

# Appendix 1

## Amor youth clinics: prerequisites for quality

### Prerequisites for services

- **Health care services:**

  *Mandatory services:* pregnancy and birth control counselling; STI prevention, testing and treatment; pregnancy diagnosis, counselling in case of unwanted pregnancy and after, genital examination and accompanying psycho-sexual counselling.

  *Recommended services:* separate reception for young males, psychological counselling.

- **Non-medical activities:**

  *Mandatory activities:* sexual education lectures.

  *Recommended activities:* telephone counselling.

### Prerequisites for staff members

- **Staff members' skills**

  *Mandatory requirements:* at larger clinics, a doctor (specialist, general practitioner, resident) and midwife/nurse; at smaller clinics, a doctor (specialist, general practitioner, resident).

  *Recommended requirements:* specialist consultant, psychologist, social worker.

- **Staff members' training**

  *Mandatory:* completed (or in the process of completing) training for work with youth, counselling training (preferably training course organized by the ESHA or its partners).

### Prerequisites for administration

***Mandatory requirements:***

- Reception for youths at separate and predetermined hours.
- Visits booked in advance as well those without appointments.
- Smaller clinics open at least two days a week with one open in the evening.
- Contact with staff members is available within three days.
- As certain and consistent visiting hours, location and staff members, as possible.
- Clear and visible information about youth clinic hours and location.

***Recommended requirements:***

- Separate hours for young males (separate from general reception).
- Automated voice messaging on telephones providing information about location, visiting hours and telephone counselling.
- Telephone counselling (counselling by telephone at specific times).
- Registration for visits is by telephone to the youth clinic/office, i.e. apart from general registration of health care institutions.

## Prerequisites for location, rooms

*Mandatory requirements:*

- Location in a place familiar to youth, such as the centre of town or village or any frequented place.
- Separate from rooms of other health care institutions.
- Rooms appropriate to activities (doctor's cabinet, counselling rooms).
- Youth-friendly atmosphere – informal, friendly and private.
- Easy access for disabled people.

*Recommended requirements:*

- Appropriate space for lectures.

## Prerequisites for equipment

*Mandatory requirements:*

- Necessary instruments and apparatus for gynaecological and male examinations; blood pressure measurements.
- Access to laboratories (STI tests).
- Necessary examples for sexual education activities and individual visits (such as menstrual cycle diagram, birth control samples and illustrations of their effect, personal hygiene product samples).
- Information materials for visitors: information pamphlets compiled by the ESHA in offices and waiting room.

*Recommended requirements:*

- Free or cheap condoms.

## Prerequisites for documentation of activities and for reports

All activities (medical and non-medical) carried out by youth clinics are documented according to data protection and other valid laws.

*Mandatory requirements:*

- According to valid Estonian legislation (such as keeping outpatient records, infectious disease reports).
- Project requirements (quarterly reports).

*Recommended requirements:*

- Collection of information on lecture and seminar participants.

## Prerequisites for cooperation

*Mandatory requirements:*

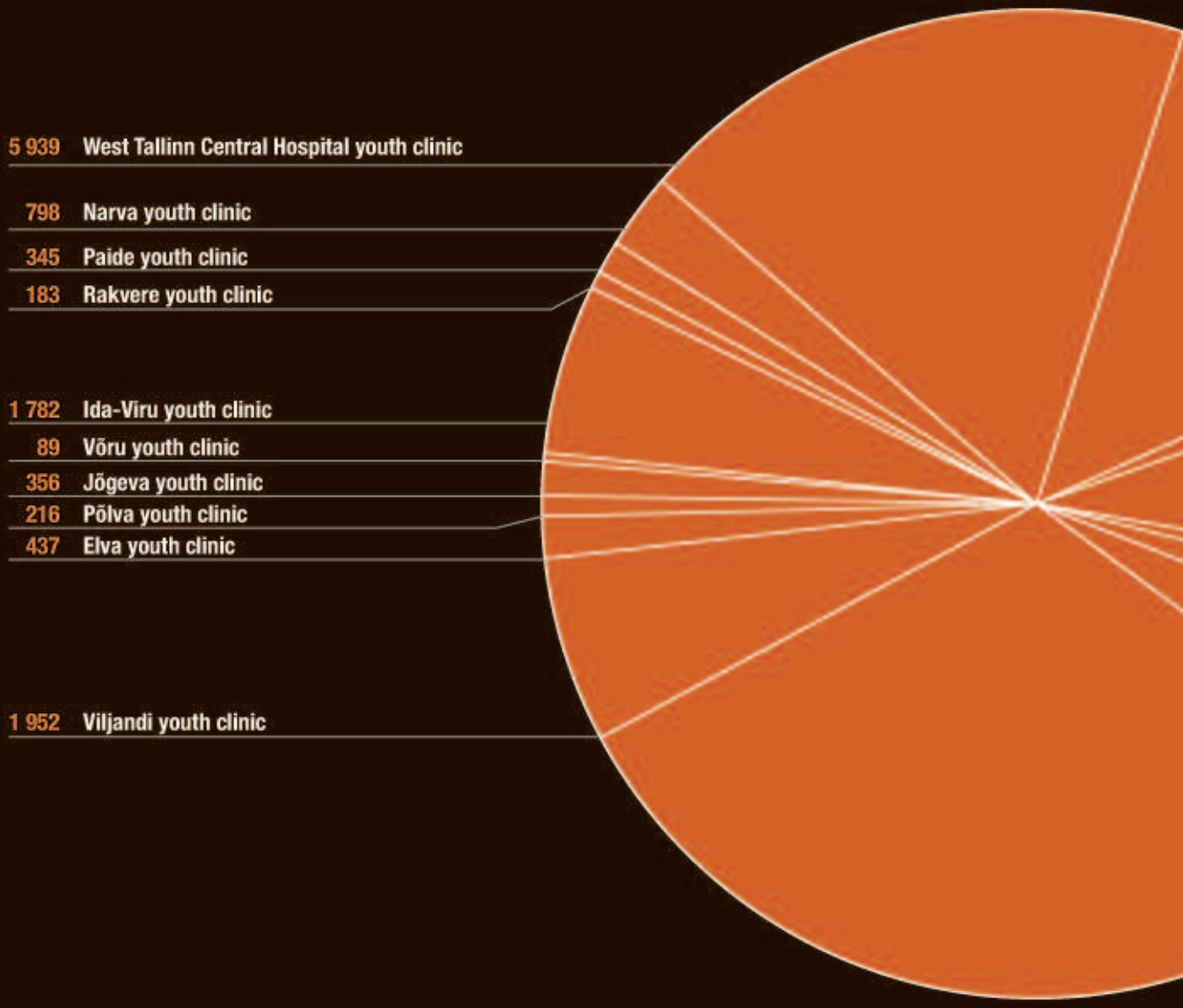
- Cooperation with the ESHA, youth clinics in the same area, schools, local government.

*Recommended requirements:*

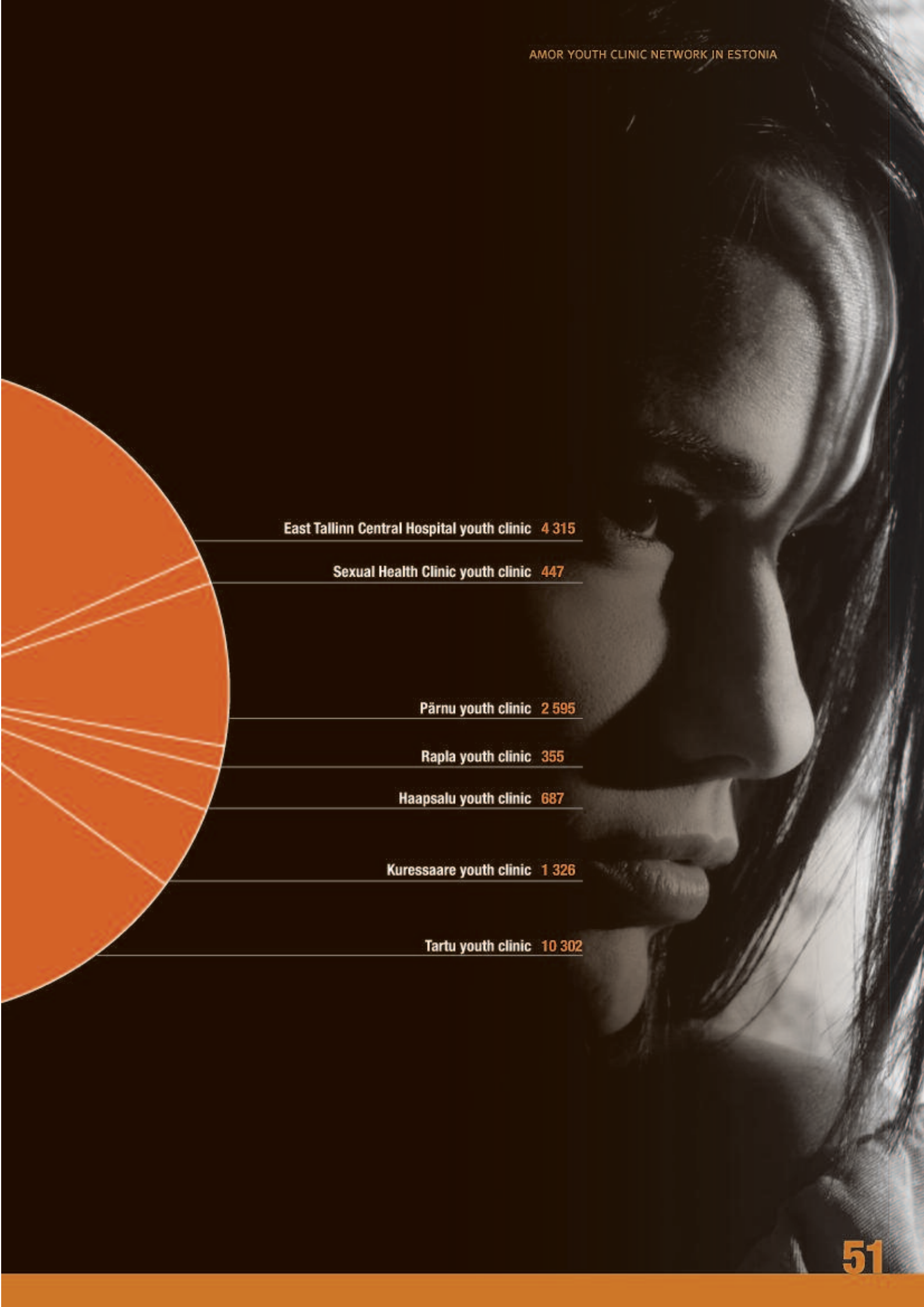
- Cooperation with other youth organizations and specialists, AIDS clinics, local government.

# Appendix 2

## Number of visits to Amor youth clinics




*Number of visits to Amor youth clinics by clinics, 2006 (total number of visits 32 124)*


East Tallinn Central Hospital youth clinic 4 315
Sexual Health Clinic youth clinic 447
Pärnu youth clinic 2 595
Rapla youth clinic 355
Haapsalu youth clinic 687
Kuressaare youth clinic 1 326
Tartu youth clinic 10 302

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World Health Organization

Following a WHO review of initiatives demonstrating increased use of health services by adolescents, policy-makers and programme managers requested more detailed information on what was being done to improve quality, including friendliness, and scale up of service coverage. In response, WHO's Child and Adolescent Health and Development (CAH) department has supported the documentation of three outstanding initiatives in developing country settings.

This document describes an initiative for quality improvement in adolescent-friendly services implemented in public sector primary health care clinics in Estonia.

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