YOUTH-FRIENDLY REPRODUCTIVE HEALTH SERVICES

AN ANALYSIS OF YOUTH OPPINIONS, ATTITUDES AND BEHAVIORS RELATED TO REPRODUCTIVE HEALTH SERVICES

-final report-

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One of the most interesting facts related to research is that answering to a question leads you to other 10 questions which you didn't have before

after BERNARD SHAW

CONTENT

1.EXECUTIVE SUMMARY

Youth, especially adolescence, are times of learning which necessarily include risk-taking, but the conditions in which those risks are taken will often make the difference between constructive and destructive outcomes. The health of youth and adolescents is profoundly linked to their development, since their physical, psychological and social abilities will determine what they do, how they act and with whom they associate. These abilities change as adolescents mature and turn into youth and adults, reflecting the degree of support and opportunity they are given.

In the attempt of elaborating appropriate interventions in the area of youth education and friendly-services in RH, the Youth for Youth Foundation tried first to better understand youth needs, thoughts and feelings experienced around the so delicate moments of sexual maturation and sexual life beginning, and their complex relations with the use or non-use of protection and medical assistance in this field.

The present study included two major components, a quantitative respectively a qualitative one. The most significant statistic data related to youth and RH were also taken into consideration, and a special part of this report presents them briefly.

The quantitative component was a school based survey, employing a two-stage cluster sample design to produce a representative sample of 492 adolescents in Bucharest, students in the grades 9-12. The qualitative part consisted of 15 in-depth interviews with young women, aged 15-24 years; this sociological technique was preferred both because of the sensitivity of the approached issue, and of the necessity of exploring in-depth the respondents attitudes and barriers towards addressing the services.

Considering the cost/effectiveness criteria and also the presumption that starting youth friendly RH services in Romania should begin with the major university centers (where much more youth congregate), the research took place only in Bucharest. Depending on the future steps decided in implementing this program, the present study could be replicated entirely or partially in other targeted/ selected cities.

The present study shows not only that youth have limited access to information and especially to communication, but also the consequences of this fact – the impossibility of making informed decisions. The general attitude that youth perceive from adults related to RH is a rejective one, along with the mentality that sexual activity in adolescence and early youth is not appropriate. Most other issues related to sexuality and RH remain under a taboo of silence. This taboo includes the medical RH services, which are not enough promoted to adolescents and youth who might need them.

The main barriers that were identified as limiting youth access to RH services are psychological. Usually adolescent girls fear that first visit to a FP/ObGyn doctor, fear that might have very different explanations and reasons; some of them could be easily overcome through open communication and information. Other barriers refer to the quality of the medical services available, especially related to doctor-patient relationship. Overcoming this type of barriers requires more efforts in changing providers' attitudes and mentalities, along with an appropriate promotion of the youth-friendly services to adolescents.

The “portrait” of youth-friendly RH services would be as follows: empathetic, kind, warm, patience staff, able to treat his patient with respect, and in the same time being a good professionist, working in a pleasant, colorful, warm and welcoming clinic. The clinic should also be placed in a discrete position and offer a lot of other services (in the same location or in collaboration with other medical clinics/ cabinets) at low costs.

By the end of the present report, a series of conclusions and recommendations are made. Since the study itself was designed with the purpose of having a practical finality, the report is closing (before the annexes) with a proposed model for developing youth-friendly services in Romania.

2. STATISTIC DATA ON YOUTH REPRODUCTIVE HEALTH IN ROMANIA

2.1. DEMOGRAPHIC SITUATION OF YOUTH

At January 1, 1999, the segment of population 15-24 was representing 16.6% (3,726,627 young people) of the total of 22,458,022 inhabitants of Romania.

The gender distribution showed a slightly higher percent of young men: 50,9%, compared with young women of the same age (15-24): 49,1%.

56,74% of youth was living in urban areas, while 43,26% was living in rural ones. Compared with previous year (1998) the percent of young people living in rural areas is a little bit higher, although this trend is more obvious for young adults that are over 24 and less than 30 years of age (from 42,1% of persons aged 25-29years living in rural areas in 1998, to 45% in 1999). One of the explanations of this phenomenon is the relatively high rate of unemployment that affects especially population in urban areas; therefore, some young people, especially those who are married and have relatives at the country prefer to move back to rural areas.

The structure of population from the point of view of civil status shows youth option for late marriage (after 25 years of age). Only about 4% of youth under 19 years of age and about 30% of youth between 20-24 years are married. Compared to these figures, about 70% of young people 25-30 years are married.

According to the National Report "Youth Policies in Romania", edited in 2000 by the Ministry of Youth and Sports and The Center for Studies and Research on Youth, youth live in poorer conditions than the general adult population. Several factors that contribute to this situation are identified and are proposed to be addressed through appropriate policies and interventions. Meanwhile, the effects of this situation remain and youth represent a vulnerable group from many perspectives, including, in the context of the present document, the access to appropriate medical care and RH services. Factors that contribute to lower standards of living are unemployment, low level of school education (more frequent in rural areas), female gender.

2.2 DATA ON YOUTH SEXUALITY AND REPRODUCTIVE HEALTH

- **Sexual experience of young adults**

Although in the past (especially before 1990) most adolescents remained sexually abstinent for most of their teen years, recent social and cultural changes were likely to liberalize sexual behavior at a higher pace than in the past. Still, in Romania the onset of intercourse is rather late among young women. Only 7% of adolescent girls below 16 years of age initiated sexual activity; this percent increases to 28% among women less than 18 years of age and to 56% before age 20. However, the proportion of 15-19 year-old women who reported sexual intercourse in 1999 increased by 62% compared with 1993 (26% vs. 16%). The comparison of the data from 1999 with the data in 1993 and 1996 revealed a very clear **trend in decreasing the age of the first sexual intercourse** in Romanian adolescents. The 1999 Reproductive Health Survey also showed that the median age of first sexual intercourse decreased from 20.5 years in 1993 to 19.5 years in 1999. Similarly to the trend in women, the proportion of 15-19 year-old boys who reported sexual experience increased, although less

dramatically (with 10%, from 1996 - 41%, to 45% - 1999).

The 1999 RHS also showed a significant **increase in premarital initiation of sexual intercourse**; in 1999, 83% of sexually experienced women aged 15-19 were not married when they first had sex, compared with 57% in 1993.

The patterns of first sexual intercourse also differ by socio-economic status. Young women of low socio-economic status (SES) were more likely to be sexually experienced before age 16 (14%) and 18 (38%), than women of middle or high status (4% and 24%, and 2% and 21%, respectively). However, the socio-economic differences are likely to reflect, in part, differences in education, as less well-educated women are more likely to be poor. Conversely, young men were less likely to be sexually experienced if they were of low SES: 23% before age 16 and 47% before age 18, compared with 30% and 64%, respectively, among young men of high SES.

- **Current sexual activity**

Overall, only 42% of all young women had intercourse within the past three months (defined this way as currently sexually active). Only 20% of teenaged females reported current sexual activity, while 62% of 20-24 year-old women reported having had sex within the previous 3 months.

- **Use of contraceptive methods by the time of the first sexual intercourse**

Contraceptive behavior at first sexual intercourse is an important indicator of the risks of unintended pregnancy and sexually transmitted infections. Several studies have shown that the risk of pregnancy among young women is highest in the few months after the first coitus.

Because contraceptive behavior is very different depending on whether the onset of sexual activity precedes marriage, contraceptive use is reported separately according to whether first intercourse was premarital or marital. The 1999 RHS showed that about 50% of sexually experienced women reported the use of some form of contraception the first time they had intercourse; withdrawal (24%) followed closely by condoms (22%) were by far the methods most often used, accounting for 90% of use. Not only did a greater proportion of young men (64%) use some form of contraception at first intercourse, but also the percentage that used a more effective method was higher than that of young women. Although 22% of young men used withdrawal as a method, 39% used a condom.

Contraceptive prevalence at first premarital intercourse among young women, that increased by 50% between 1993 and 1996 (from 26% to 39%), continued an upward trend reaching 58% in 1999. Almost all the increase in use was the result of the increased use of condoms.

- **Use of contraception at most recent sexual intercourse**

Among sexually experienced young women, regardless of the timing of their last sexual intercourse, contraceptive prevalence on that occasion was relatively high (70%). Furthermore, contraceptive use at last intercourse was equally likely to be a modern method or a traditional method. The most prevalent method continued to be withdrawal, which was used by 31% of couples, followed by condom (19%) and the pill (12%). Among young men, the overall data were similar.

Patterns of contraceptive use at last intercourse by women were strongly influenced by marital status. Contraceptive use was significantly higher among women not currently married than among those in legal or consensual marriages (79% vs. 62%). The greater use of contraceptives among unmarried women was the result of proportionally greater use of modern methods (47% vs. 25%) whereas use of traditional methods was lower (32% vs. 37%).

- **Statistic data on pregnancy and abortion among young adults.**

Fertility in Romania exhibits an early peak in the age pattern, with the highest level among 20-24 year-old women (100 births per 1,000 women aged 20-24). Fertility among adolescent women is the third highest (36 births per 1,000 women aged 15-19 years), after the age group 25-29 years (RRHS 1999). As a result, 52% of the TFR was contributed by women aged 15-24 (TFR - total fertility rate is defined as the average number of births a woman would have during her reproductive life time; in 1998, the TFR for Romania was 1.2 births/ woman aged 15-44 years).

The age-specific fertility rates were higher among rural residents; for the age group 15-19 years the specific fertility rate is three times higher in the rural areas than in urban ones, while for the age group 20-24 it is only two times higher.

In 1999, 2% of adolescents and 16% of women aged 20-24 years reported induced abortion. The age-specific **abortion** rates are 101 abortions/ 1,000 women 20-24 years, respectively 26 abortions / 1,000 women 15-19 years. These figures (which are the rates reported to an absolute number of 1,000 women of that age) are lower than the values for the age groups 25-29, respectively 30-34 years. Still, if we take into consideration the percent of women who are currently sexually active per each age group (about 42% of women aged 15-24, compared with about 86% of women 25-44) and therefore at risk for getting pregnant, the number of abortions/ sexually active women 15-24 years is comparable or even a little bit higher than the value of the same indicator for any other age group.

3.GOAL AND OBJECTIVES OF THE PRESENT STUDY

GOAL

To understand and document youth knowledge, opinions, attitudes and behaviors related to the act of addressing medical RH services.

OBJECTIVES

- to understand better youth mentalities related to RH and sexuality;
- to understand how medical RH services are perceived by the youth;
- to understand the barriers youth face in the process of addressing medical RH services;
- to understand how medical RH services should be designed in order to overcome the identified barriers
- to identify the most desirable location for youth friendly services (hospital, policlinics, school cabinets, etc)
- to make strategic recommendations for developing youth-friendly services in Romania.

4.RESEARCH METHODOLOGY

4.1.General Considerations

In order to accomplish the above mentioned goal and objectives, the research was designed to have two parts, a quantitative respectively a qualitative component.
Considering the cost/effectiveness criteria and also the presumption that starting youth friendly RH services in Romania should begin with the major university centers (where much more youth congregate), the research took place only in Bucharest. Depending on the future steps decided in implementing this program, the present study could be replicated entirely or partially in other targeted/ selected cities.

4.2.The quantitative component

The quantitative component was a school-based survey, employing a two-stage cluster sample design to produce a representative sample of students in Bucharest, grades 9-12.

In order to have an accurate sampling frame, the Bucharest School Authorities was kindly requested to facilitate the access to the existing data base on high-school, classes and students in Bucharest. The first-stage sampling frame contained the 106 high-school units in Bucharest, considered as primary sampling units. 5 high schools were randomly selected from the 106. The second stage of sampling consisted of randomly selecting for intact classes from grades 9-12 in each chosen school. All students in the selected classes were eligible to participate in the survey.

Survey procedures were designed to protect the students' privacy by allowing for anonymous and voluntary participation. The self-administered questionnaire was administered in the classroom at the beginning of a regular class period. The participant were informed upon the nature of the survey and were assured that the data would be used for the research purposes only. Anonymity was also guaranteed by avoiding any personal identification information.

The participants in th study were in number of 492 (246 females and 245 males), students in 9^{th}, 10^{th} and 11^{th} grades; thir age ranges between 14 and 19 years with a mean of 17 years. The response rate was 98,2% (492 students responded from a total of 501 included in the sample).

The process of questionnaire design included consultations with several students, teachers and school principles. In order to be allowed to apply the questionnaire to students, during the classes, it had to be brief and not to include questions related to the students personal experiences (i.e. Have you ever been to a family planning clinic?), considered too intrusive. The items used for data collection in this study were part of a larger questionnaire.The final questionnaire is presented in the end of the report (see Annexes part).

Four scales were used for the purpose described above and they are as follow:

Scale 1
Was designed to identify the adolescents preferences for FPS location and it has 6 items.
The respondents had 6 choices of answer for 5 items (1, the most appropriate place to 6, the least appropriate place) and free answer for the 6^{th} item.

"Below there are several places where adolescents can use the family planning services. If you needed these services, where would you rather go:"
GP office, FP office in a hospital, FP office in a clinic, private FP office, health services in school, other suggestions.

Scale 2
Ten items were designed to identify reasons for which the adolescents do not use the FPS at the moment and attitudes towards family planning services, as they are perceived now.
The respondents used a Lickert's scale with 5 values to answered 9 of the items (0-strongly disagree, 1-desagree, 2-neither agree nor disagree, 3-agree, 5-strongly agree)
And were free to answered the 10^{th} item.

Scale 3
Was built to identify knowledge and prejudices the adolescents have about FP services based on 7 items with dichotomic answer (yes/no) and 1 opened question.

Scale 4
8 items were designed to see if the adolescents perceive them self as clients of FPS.
The respondents had a choice of dichotomic answer (yes/no) for 8 items and free answer for the 9^{th} item.

4.3.The qualitative component

The qualitative part of the present study consisted of 15 in-depth interviews with females, aged 15-24 years. This sociological technique was preferred both because of the sensitivity of the approached issue, and of the necessity of exploring in-depth the respondents attitudes and barriers towards addressing the services.

The interview guide was developed based on several preliminary discussions with young girls, up to 24 years of age. It included distinct sections for discussions with girls who had ever accessed reproductive health services, and for discussions with girls who had never done it.

Prior to the interview procedure, the respondents were informed about the purpose of the study, about the potential sensitivity of some questions and the non-obligativity to answer to them. It was also highlighted the confidentiality of the research. The respondents were also asked for their permission to audio-tape the interviews, and 12 of them agreed to that, while 3 did not (and the interviews were not taped).

5.RESULTS OF THE QUANTITATIVE RESEARCH

Descriptive statistics were performed to analyse data collected and the results are presented in the tables I, II, III, and IV.
The results are presented for all participants as well as differentiated by gender.
The results of opened questions analysis are presented at the end of each table with items they were related to.

The participants' answers reflect :
- the adolescents' perception of their needs
- the adolescents' knowledge and prejudice
- the adolescents' reasons for their present and future behavior
- the adolescents' intention to use the FPS
- the adolescents' attitudes towards FP and FPS as they are perceived now.

The results showed that most adolescents would preferred to go to a private FP office, but the G.P.' office (the second place in the preferences' order) is also to be considered. The least appropriate place the adolescents consider to be the health services in school, followed by FP office in hospital.

Regarding the reasons which influence the adolescents' decision to use or not the FP services we summed the response options 'strongly agree', 'agree' and 'neither agree, nor disagree' to count the reason's weight. Therefore exception item E ('Only married people need FPS), the other reasons have a relative equal and extremely high value ranged between 65,1% to 79,4% in their influence on adolescents decision.
The most frequently reported reason was 'Shame/ fear against gynecological examination'- 79,4% followed by 'Attitude and /or medical staff behaviour'- 76,2%, 'The FPS cost' 74,8%, 'Fear to be seen by their parents'-72,1%, 'The adolescents didn't start their sexual life'- 71,3%, 'The hostility of the public opinion'-69,3%, 'The contraceptives 'cost'- 69,1%, 'The use of natural contraception'-65,1%.
The item E described above, has the lowest frequency: 36,7% but regarding the content it is still important.
The proportion of the participant who 'disagree' all the reasons is 0. Which means that an adolescent faces at least one powerful barrier in his decision and action toward a healthy sexual behaviour.

The reasons described above could be associated with:
- knowledge/ prejudice: (a), (e), (g), (i)
- attitudes: (a), (e), (g), (i)
- social norms: (b), (f)
- the quality of FP services: (c)
- economical factors: (d), (h)

70 % of the participants have poor information about FP services, as the answers recorded in the 3th scale showed here. They do not exactly know what the FP services are.

60% of adolescent out of the total number of respondents perceived them selves as potential clients of FP services but their answers showed also confusion concerning the general clients.

Conclusions

- The adolescents face a lot and strong barriers in order to adopt and promote a safe behavior for the reproductive health using the FPS at the moment.
- In the organization of the family planning services specific to the adolescents high attention has to be paid to the location of these services.
- The FP staff needs specific training adjusted to adolescents needs.
- Information campaigns are extremely important and they should be designed to target the adolescents as well as their parents.
- Programs for behavior development and change should be designed on the successful theories of behavior planning.

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Table I.

(From the right to the left: 1-the most appropriate place, 6- the least appropriate place)

FPS office localisation		**1**	**2**	**3**	**4**	**5**	**6**
G.P.'s office	Tot.	157 **38,5%**	61 **15,0%**	49 **12%**	64 **15,7%**	38 **9,3%**	37 **9,1%**
	F	66 **16,2%**	29 **7,1%**	29 **7,1%**	40 **9,8%**	24 **5,9%**	21 **5,9%**
N 408 = 100%	M	90 **22,1%**	32 **7,8%**	20 **23,7**	24 **5,9%**	14 **3,4%**	16 **3,9%**
FPS office in hospital	Tot	36 **9,7%**	58 **15,7%**	95 **25,7%**	80 **21,6%**	51 **13,8%**	50 **13,5 %**
	F	15 **4,1%**	32 **8,6%**	52 **14,1%**	46 **12,4%**	27 **7,3%**	22 **5,9%**
N 370= 100%	M	21 **5,7%**	25 **6,8%**	43 **11,6%**	34 **9,2%**	24 **6,5%**	28 **7,6%**
FPS office in clinic	Tot	36 **9,7%**	72 **19,5%**	85 **23%**	100 **27,0%**	48 **13,0%**	26 **7,0%**
	F	20 **5,4%**	37 **10,0%**	48 **13,0%**	54 **14,6%**	23 **6,2%**	13 **3,5%**
N 370 = 100%	M	16 **4,3%**	35 **9,5%**	36 **9,7%**	46 **12,4%**	25 **6,8%**	13 **3,5%**
Private FPS office	Tot	180 **46,4%**	59 **15,2%**	54 **13,9%**	36 **9,3%**	28 **7,2%**	28 **7,2%**
	F	113 **29,1%**	34 **8,8%**	23 **5,9%**	15 **3,9%**	13 **3,4%**	8 **2,1%**
N388= 100%	M	67 **17,3%**	25 **6,4%**	31 **8,0%**	20 **5,2%**	15 **3,9%**	20 **5,2%**
Health Services in School	Tot	58 **15,2%**	56 **14,7%**	41 **10,7%**	33 **8,6%**	125 **32,7%**	68 **17,8 %**
	F	32 **8,4%**	31 **8,1%**	18 **4,7%**	14 **3,7%**	70 **18,3%**	39 **10,2 %**
N 382= 100%	B	26 **6,8%**	25 **6,5%**	23 **6,0%**	19 **5,0%**	54 **14,1%**	29 **7,6%**

Item 20f: other options suggested by adolescents:
friends; psychology office; church; family, pharmacy; hotline; more friendly persons and places.

Table II.

Reasons which influence the adolescents' decision to use the FPS

Reasons		Strong disagree	Disagree	Neither agree nor disagree	Agree	Strong agree
A. The adolescents didn't start the sexual life	Tot	58 **12,6%**	73 **15,9%**	126 **27,3%**	112 **24,3%**	90 **19,6%**
	F	25 **5,4%**	39 **8,5%**	50 **10,9%**	50 **10,9%**	52 **11,3%**
	M	32 **7,0%**	34 **7,4%**	62 **13,5%**	62 **13,5%**	38 **8,3%**
N460 = 100%						
B. The public opinion disagree	Tot	50 **10,9%**	73 **16,0%**	108 **23,5%**	155 **33,9%**	78 **17,1%**
	F	16 **3,5%**	36 **7,9%**	50 **10,9%**	83 **18,2%**	34 **7,5%**
	M	33 **7,2%**	36 **7,9%**	57 **12,4%**	72 **15,8%**	44 **9,6%**
N459 = 100%						
C. The attitude and/or medical staff behaviour	Tot	35 **7,7%**	73 **16,0%**	115 **25,2%**	155 **33,9%**	78 **17,1%**
	F	20 **4,4%**	36 **7,9%**	59 **12,9%**	83 **18,2%**	34 **7,5%**
	M	15 **3,3%**	36 **7,9%**	55 **12,1%**	72 **15,8%**	44 **9,6%**
N456 = 100%						
D. The FPS 'cost	Tot	44 **9,5%**	72 **15,6%**	106 **22,9%**	136 **29,4%**	104 **22,5%**
	F	16 **3,5%**	38 **8,%**	55 **11,9%**	73 **15,8%**	53 **11,5%**
	M	27 **5,8%**	34 **7,4%**	51 **11,0%**	53 **11,5%**	50 **10,8%**
N462 = 100%						
E. Only married people need FP	Tot	144 **31,3%**	147 **63,3%**	80 **17,4%**	48 **10,4%**	41 **8,9%**
	F	92 **20,0%**	73 **15,9%**	34 **7,4%**	21 **4,6%**	14 **3,1%**
	M	52 **11,3%**	73 **15,9%**	46 **10,0%**	27 **5,9%**	26 **5,7%**
N460 = 100%						
F. The adolescents could be seen by parents, parents friends, teachers, etc	Tot	46 **10,0%**	91 **19,8%**	117 **25,4%**	123 **26,7%**	83 **18,0%**
	F	15 **3,3%**	45 **9,8%**	51 **11,1%**	78 **17,0%**	45 **9,8%**
	M	30 **6,5%**	46 **10,0%**	65 **14,2%**	45 **9,8%**	38 **8,3%**
N460 = 100%						
G. Shame, fear against gynaecological examination	TOT	36 **7,9%**	58 **12,7%**	77 **16,8%**	138 **30,1%**	149 **32,5%**

	F	14	27	28	77	88
		3,1%	**5,9%**	**6,1%**	**16,8%**	**19,3%**
	M	22	30	49	61	60
N458 =100%		**4,8%**	**6,6%**	**10,7%**	**13,3%**	**13,1%**
H. The contraceptives' price						
	Tot	54	88	132	134	51
		11,8%	**19,2%**	**28,8%**	**29,2%**	**11,1%**
	F	23	52	66	75	19
		5,0%	**11,4%**	**14,4%**	**16,4%**	**4,1%**
	M	30	36	65	59	32
N458 =100%		**6,6%**	**7,9%**	**14,2%**	**12,9%**	**7,0%**
I. Using natural contraception		65	84	146	111	46
	Tot	**14,4%**	**18,6%**	**32,3%**	**24,6%**	**10,2%**
		26	56	64	62	22
	F	**5,8%**	**12,4%**	**14,2%**	**13,7%**	**4,9%**
		39	27	81	49	24
	M	**8,6%**	**6,0%**	**18,0%**	**10,9%**	**5,3%**
N451 = 100%						

Item 21j: other reasons suggested by adolescents:
the lack of information; the medical staff' lack of interest ; the adolescents don't trust the FPS and the personnel involved; the adolescents do not want to take the responsibility; the fear of unknown; wrong information; the fear against a new thing; the lack of money.

Table III.

Adolescents knowledge about FPS

Family Planning Services		Yes	No
A. Fill in a questionnaire.			
	Tot	186 **39,8%**	281 **60,2%**
	F	93 **20,0%**	145 **31,2%**
	M	92 **19,8%**	134 **28,8%**
N467 = 100%			
B. Fill in a medical record.			
	Tot	134 **28,6%**	333 **71,2%**
	F	80 **17,2%**	157 **33,7%**
	M	50 **11,4%**	174 **37,3%**
N467 = 100%			
C. General medical examination.			
	Tot	198 **42,3%**	269 **57,5%**
	F	103 **22,1%**	134 **28,8%**
	M	94 **29,2%**	133 **33,5%**
N468 = 100%			
D. Gynaecological examination			
	Tot	188 **40,3%**	279 **59,7%**
	F	16 **24,9%**	122 **26,2%**
		70	156
N467 = 100%	M	**15,1%**	**33,5%**
E.Intrebari inutile			
	Tot	70 **15,0%**	398 **85,0%**
	F	21 **4,5%**	218 **46,8%**
		48	178
N 468 = 100%	M	**10,3%**	**38,2%**
F. Counselling (an interactive dialog between the FP worker and the client			
	Tot	325 **69,4%**	143 **22,8%**
	F	184 **39,5%**	54 **11,6%**
		139	88
N468 = 100%	M	**29,8%**	**18,9%**

G. Writing a receipt for contraceptives. N467 = 100%	Tot	150 **32,1%**	317 **67,9%**
	F	88 **18,9%**	150 **32,3%**
	M	61 **13,1%**	165 **35,5%**

The response option ‘Yes’ or ‘No’ is important depending on the question.

Item 23h: other FP services available :
Plans for the future; how to avoid the family arguments; an usual checking; abortion;

Table IV.

Whom the adolescents think the FPS are addressed to

FPS clients	Yes	No
E. Married women Tot F M N 464 = 100%	145 31,3% 85 **18,4%** 60 13,0%	319 **68,8%** 151 **32,7%** 165 **35,7%**
B. Couples Tot F M N468 = 100%	341 **72,9%** 175 **37,6%** 165 **35,4%**	127 **27,1%** 61 **13,1%** 64 **13,7%**
C. Girls who started their sexual life. Tot F M N466 = 100%	269 **57,7%** 159 **34,3%** 107 **23,1%**	197 **42,3%** 78 **16,8%** 119 **25,6%**
D. Unmarried girls who believe they are pregnant. Tot F M N465 = 100%	258 **55,5%** 144 **31,1%** 113 **24,4%**	207 **44,5%** 92 **19,9%** 113 **24,4%**
E. Girls who were pregnant and want to avoid this situation to happen again Tot F M N465 = 100%	217 **56,7%** 125 **27,0%** 92 **19,2%**	248 **53,3%** 111 **24,0%** 134 **28,9%**

F. Women after baby delivery Tot	124 **26,7%**	341 **73,3%**
F	68 **14,7%**	168 **36,3%**
B N 465 = 100%	56 **12,1%**	170 **36,7%**
G. Girls and boys who didn't start their sexual life but want to be informed Tot	279 **60,0%**	186 **40,0%**
F	159 **34,3%**	77 **16,6%**
M N465 =100%	119 **25,7%**	107 **23,1%**
H. Both partners Tot	301 **64,6%**	165 **35,4%**
F	166 **35,8%**	71 **15.3%**
M N466 = 100%	134 **28,9%**	92 **19,8%**

The response option 'Yes' or 'No' is important depending on the item.

Item 24i: other clients of FPS
Divorced parents; maltreated, abused women; persons under the suspicion of having a STD

RESULTS OF THE QUALITATIVE RESEARCH AND CONSIDERATIONS RELATED TO YOUTH-FREINDLY SERVICES

The focus of this research component was on youth attitudes, opinions and use of reproductive health services. Still, this qualitative study revealed some aspects of what could be called a "psychological portrait" of Romanian youth and the way they perceive their life, including their sexual activity and the circumstances of first sexual intercourse and sexual activity in girls. These insights might offer a clearer understanding of youth mentality in the area of RH and sexuality and might help in understanding why youth-friendly services are needed and how they should be like, in order to meet youth needs. Also, considering the recently started program of introducing Health Education in Romanian Schools, these considerations might be helpful also in the process of curriculum and manuals' development. Therefore, the results of this study are presented in two parts: the first one would try to highlight some of these "psychological" insights, while the second will focus specifically on youth experience related to RH services' use and barriers in accessing RH services. In the end of the chapter, a final part, titled "Considerations related to the development of youth-friendly services" would try to analyze the way youth friendly-services should be designed, based on the identified barriers and on the experiences in using RH services, described by respondents in the study.

A. Results: psychological insights

1.Youth perceptions on existing sources of information and education in the area of RH and sexuality

Youth access to correct information is limited; the main information sources are mass-media and friends, considered as the most secure, although not always trustable. The source of information youth would rely the most on, is medical staff. Still - there are a lot of barriers that lead to low access to medical services (as will be detailed below). Parents and teachers do not represent a significant source of information, although youth would very much like the situation to be the opposite.

Lack of communication on RH issues with adults and its implications. Mainly, what adolescents feel lacking more than the information itself, is the lack of communication on RH and sexuality issues, especially with adults. Existing conservatives mentalities, which presume that knowledge in this area would lead to earlier sexual debut, adults' lack of information along with huge difficulties in approaching this type of subjects in usual conversations with young generation, determine many parents and teachers to avoid (or not even consider) RH as a matter of discussion with their children/ students (according to youth perceptions). Despite the rebel attitude characteristic to this age, the adults opinions and attitudes (usually the most "accessible" adults around are parents and teachers) related to sexuality and reproductive health are still important for many adolescents. The parents' disapproval on sexual activity represents for girls one of the most important reasons for not having sex until a certain age/ marriage.

Although information might be available in books, brochures, etc, it is rather ineffective in the absence of an informed person to discuss these issues with. The difference will not be as much obvious at the level of knowledge youth have, but at the level of applying this

knowledge in practice, respectively protection and responsibility, including the use of medical RH services. Comparing the girls that have had the opportunity to discuss open these issues with an adult (mother, elder sister, etc), with the girls who did not, it is a noticeable difference in their attitudes on sex, protection and use of medical services. Education must necessarily involve open discussions, since they make a noticeable difference in the area of assuming responsibilities, including protection against unwanted pregnancy and STIs, and use of services.

*2.**Insights related to the moment of sexual debut and need of communication on this issue.***

The moment of the first sexual intercourse is a very delicate decision a girl has to make. Usually (as revealed during the interviews and discussions during the Strategic Evaluation of Abortion and Contraception Situation in Romania) she has to balance the "pros" and "cons", but this balance is not a stable one. The importance of certain arguments may enhance in time or, by contrary, pale; other arguments may be raised or other pressures may appear later, especially in the area of "pro" factors. In many cases, lack of correct information and lack of communication may lead to inability of considering all the factors in the balance.

After a young girl considers for the first time in her life the possibility of becoming sexually active, she will go through a rather difficult period of indecision. A lot of arguments could be identified on both sides, and "to start or not to start" your sexual life might be in some cases the most dramatic dilema in the teen years. The process in reality is not as "mathematical" as described above and in most of the cases the teenager is not really aware of it, but it is happening.

In many cases this decision is made by the adolescent alone, without consulting other persons, but sometimes her boyfriend (not even close friends). It could be said that this decision represents her first exercise of independent choices. On the other hand, deciding on your own is a difficult thing itself, since adolescents do not have the "practice" in making their own decisions. Parents were in many cases those who had greatly contributed to making the important decisions in their children's life so far, and in this particular issue they can not be consulted; this explains youth desire to approach this topic with their parents within open discussions, but the lack of communication is again involved. The degree of independence an adolescent girl has gained in her relationship with the parents is an important variable in the process of starting her sexual life. The more dependent she is, the more difficult it will be for her to make such a decision, and the greater the psychological tensions are. Another observation is that the degree of independence/ dependence is not always proportional with the age of the teenager.

Saying "yes" and having the first sexual intercourse does not usually represent a deliberated and "cold-blood" decision, but a moment-taken one - moment when the "pros" weighted more than the "cons". The younger and more independent the girl is, the greater are the chances for this to happen (due to a lower exposure to information and education on these themes and also to lower abilities of saying "No" to her partner).

The implications of the above are first in the use or not-use of protection by the time of the first sexual intercourse. According to the 1999RHS, the most common reasons for not using a contraceptive method when having the first sexual contact, in the absence of any intention for getting pregnant, were "Unexpected sexual intercourse" and "I did not think about contraception".

3. Other considerations: becoming involves risk-taking, low self-esteem and vulnerability

It is also important in this context to highlight that youth and especially adolescence represent times of becoming, of searches, but also of risk -taking. Youth is the time of "first time" and this includes first "great love", first visit to an RH specialist, or in some cases first unwanted pregnancy. All the emotions at this age are more powerful and "colored" than later - the first love is greater, and sadder will be the experience of a first unwanted pregnancy and abortion.

Adolescence and youth are also times of self-searching; since you don't know too well who you are, which are your qualities, your defects and your limits, you have no other chance but to look for them - to look for yourself. Usually, this is a long process and involves periods of low self-esteem and low self-confidence. Correlated with an unclear values system, sometimes with low education and low socio-economic status, and different external pressures, these factors may lead to different degrees of social vulnerability, exposure to abuses and incapacity/ lack of self-protection.

At this age, youth - especially girls - are much more focused on the affective aspects of their relationships and less concerned about the physical consequences that may appear. Girls are vulnerable in the trust and affection they offer to their partners, and therefore sometimes they may expose themselves to acknowledged risks for the seek of the relationship. This is a very important argument for considering men's education in this area as an aspect that has not to be neglected.

In the same time, usually girls are vulnerable to the judgmental attitudes of peers and/ or adults. Once they started their sexual life, they may experience feelings of guilt that would enhance the vulnerability in front of critical attitudes from adults.

But all these represent in the same time the basis to explain why, when unexpected consequences of their action appear (as the case of an unwanted pregnancy), adolescents are usually not prepared and the implications may be very dramatic.

B. Results: youth experience related to RH services' use and barriers in accessing RH services

When discussing about the first visit to an RH medical clinic, almost all young women described a general feeling of fear. Although reasons for feeling this way, identified and detailed below, might be very different, it is clear that it needs time, effort and good reasons/ motivations for the adolescents to overcome them and get to a medical clinic. For overcoming some of the barriers described below, appropriate behaviors and interventions from the "adults world" may be helpful and effective.

- **Concerns related to potential judgmental and critical attitudes from the medical staff**

The very first visit to a RH medical service represents another "first time" in the context of adolescence being an age of "first times". But addressing this type of services means for most of them a second step after having "the first" sexual intercourse. Those adolescents who are as responsible as to visit a doctor even before ever having had sex are few. For most of the girls who are not married and sexually active, addressing such services represents somehow a "public statement" of the fact that they "did it". A public statement in front of the persons who will happen to be in the same waiting room with you, a public statement in front of the doctor you go to. The doctor is in most of the cases the first adult person who you will share

your intimate secrets with; your privacy will be analyzed for the first time through the eyes of an adult, who might be less open and much more judgmental than your partner or closest friends - who might have been so far the only persons who knew your secret.

For most teenaged girls, this is a rather difficult moment; having in the past the opportunity of discussing about sexuality and RH with another adult (parents, teachers, etc) could be of much help in overcoming this barrier. Once you decided to go to such a clinic, an empathetic and non-judgmental attitude from the medical staff is also critical for the young patient comfort.

- **Concerns related to potential lack of respect**

Another barrier is the discomfort at the idea that the doctor, even in the absence of a judgmental attitude, might treat her disrespectfully (be in a hurry, not empathetic and give her time to open up and talk, patronizing, sometimes even yelling, asking the patient to get undressed or consulted in the same room with other persons, etc).

Unfortunately, the medical system and medical providers of all specialties in Romania are very much associated with these characteristics. The medical system is not client-oriented at all, and the population, including youth, can sense that from any minor experience related to an illness in the past. It is very likely that even from early ages, youth hear adults' testimonies on unpleasant experiences related to the medical system, and incorporate them into a "going to a doctor only when you need it badly" behavior.

Moreover, a few of the respondents in the study described such situations that happened to themselves or to close friends, when going to RH services (especially ObGyn cabinets). These unpleasant experiences become stories told from one friend to another, that certainly influence the decision of going to a specific medical cabinet, but in the same time might influence as well even the decision of using medical services at all.

Therefore, other important characteristics of the doctor should be patience, professionalism including capacity to answer to all the questions the patient asks, and the ability to listen, and show interest and respect for the *person* in front of him, not the *case* he has to solve from a scientific perspective. Intimacy represents one of the fundamental rights of the patients, and an extremely important aspect for their comfort, which has to be considered and respected accordingly.

- **Shame and discomfort in discussing about RH issues**

A distinct identified barrier (even if in place for much fewer women) is represented by the idea of sharing intimate issues with a stranger. Sometimes, even the idea that they would have to discuss about RH creates a barrier in itself. This is usually the case of very shy and non-communicative young women, sometimes with strong religious beliefs, who usually start their sexual life later/ after marriage.

- **Fear of the gynecological exam**

Fear of the gynecological exam and procedures is one of the most important barriers that keep adolescents away from medical cabinets. The majority of adolescents consider that a visit to any RH cabinet, and especially the first one in your life, will necessary include an ObGyn exam, which you can not refuse. The possibility of having just a "conversation" with the doctor is not very much considered as viable.

For most adolescents, raised and educated to shame on their genitals, the gynecological table is something like a "moral torture". The image of themselves, necked and exposing their genital area to the eyes of a stranger, is pretty unacceptable for many of them. Probably the more sexuality and RH represented a taboo and "shameful" subject in a girl's childhood, the greater has to be her effort to overcome this barrier related to a visit to a medical RH clinic. Although the adolescents *know* that the doctor is a specialist, they still can not ignore that he/she is another human being. Related to this issue, most of them prefer and even actively search for a woman gynecologist, especially for their first visit.

Many adolescent girls find out about this type of exam from peers, and not from family. Usually this is not a subject for discussions not even with friends, and every girl has to deal, more or less alone, with its own fears and prejudices.

In the same time, the ObGyn exam is sometimes considered as a potential unpleasant (physically) or even a painful one. Some of the girls who experienced it have this opinion: "the tools that were used were cold", "I could not relax and it was rather painful", etc.

- **Fear of "hidden illnesses" that might be discovered**

Another barrier that was identified (even if it is probably of small importance) is the fear that, after all, when a doctor consults you, a "hidden illness" might be discovered. Although this small degree of fear could exist in the situation of healthy adolescents, it becomes particularly true for girls who have menstrual disorders (dismenhorhea, irregular menstrual cycles, etc).

On the other hand, it is interesting to observe that the existence of minor disorders could represent a factor that helps girls in addressing a RH clinic. The explanation is that in this situation they are considered "ill" and therefore need the help of an ObGyn, instead of "being healthy and having sex". This difference in the reasons for which they go to the clinic makes in their minds a significant difference in their image in the doctors' eyes. Other barriers - the risk for judgmental attitude from the staff, the fear for lack of confidentiality, the fear that relatives might see them - are anulated in this case.

- **Fear of being "desconspired"**

An important barrier is also the fear that the visit to the medical cabinet might "desconspire" their sexual activity. Lack of confidentiality of the clinic staff, along with the possibility to be seen by parents, parents' friends, relatives, etc. while entering, waiting or leaving the clinic are risks that the adolescent has to assume.

In this context could be included the observation that usually young persons avoid addressing their family doctors or the school doctors with RH-related problems, since they present a higher risk for getting in touch with their families or teachers. This issue is also related with general concerns regarding the lack of confidentiality surrounding the available medical services.

In this regard, the location of the clinic is important. Probably the more circulated is the street in front of the clinic, the greater are youth concerns related to potential "accidents". One of the interviewed adolescents expressed her concerns related to a clinic in Bucharest that did not have curtains in the waiting room, and the people inside where likely to be seen from the street. A solution for youth in large cities is to select a clinic that is not in the neighborhood - as related by other interviewed girl.

Another concern is related to the fact that many FP clinics in policlinics or hospitals have a waiting room in common with different other medical cabinets. Therefore, not only that

during the waiting period (which sometimes may last for more than an hour) you have to face critical attitudes from adults waiting there also (this might be true or only perceived this way by the adolescents), but it increases the risk of meeting known persons.

- **Negative implication of friends, especially of the partner**.

Undoubtfully, the close friends and especially the partner, might represent factors that either encourage or discourage a young girl to go to a RH doctor - depending on their own knowledge, opinions and attitudes, behaviors or even previous experience. Most of adolescents discuss in general about RH and sexuality issues with their friends (within limits that depend on the persons involved and the context). The "word of mouth" from peers represents probably the most powerful tool in influencing somebody's opinions and behaviors. Recommendations of RH clinics or services from persons who used them themselves and were satisfied represent the modality of selection the clinic where to go yourself, in most of the cases.

The partner himself plays an important role in the use of medical RH services. More than other medical-related issues, RH should represent a concern of both partners in the couple. The partner could represent sometimes a barrier in accessing the RH services, while in other cases (as the situation of one interviewed person in our study) he can be a motivating one.

In many cases, adolescent girls have older sexual partners, who were already sexually experienced when starting the relationship with them. Therefore, they are considered by the girls better informed and reliable in sexual matters. In this context, they could represent a barrier to the service-use not only in the case when they clearly statuate that they don't find this visit necessary, but also if they are indifferent and not sustain such an initiative from their girlfriends.

One of the adolescents in the study told us that not only her partner was the person who convinced her to go to a clinic, but also unless he came with her there, she would have left the clinic while staying in the waiting room. This story proves the importance that males' active support could have in this matter, and the fact that men have to be a target for educational programs and youth-friendly clinics, just as women are.

- **Other barriers**

  Other barriers that limit youth access to RH services are:

  - lack of information and myths regarding contraception, FP services and RH in generally;
  - lack of information related to the importance of use, and availability of medical RH services;
  - low awareness of risks involved by unprotected sexual intercourse.

C. Considerations related to the development of youth-friendly services

During the discussions with the respondents in the study, it was pretty clear that, from far, the first three most-important characteristics of a RH service, from the youth perspective are (listed in order of importance):

- empathetic, kind, warm, patience staff, able to listen and answer to all the client's

questions and to treat his patient with respect

- staff with good professional skills
- pleasant environment (funny, colored, designed in a youth manner).

In the above described considerations related to socio-psychological and communication particularities of this age, and identified barriers in the use of medical services, a very strong (maybe even the strongest) youth concern was the confrontation with the doctor, as a person, and less as a medical staff. Therefore, it is very understandable why young girls placed the doctors' "human" qualities as the most important characteristic of a youth-friendly clinic. Respect is a characteristic that was stressed out repeatedly during the discussions with youth, as an issue of maximum importance for the perceived quality of services.

In the same time, it is probably important to highlight that the nurses are rather not considered as potential providers of services or counseling. Probably this is a reflection of a more general mentality of the population that considers doctors as the only potential providers of reliable medical services.

The professional abilities of the staff, despite of the second position that are taking, represent also an important concern for the quality of a youth-friendly RH service. Still, most of the interviewed girls considered that if they were in the position of choosing between a friendly provider and a better profesionist, but with a hostile attitude, they would choose the first one.

The way a clinic is decorated is also important for the young clients, especially during the waiting time, before the consultation. Most of the interviewed girls complained about the conservative way the RH clinics (especially the public ones) look: everything dressed in white, old furniture, old equipment, insufficient light, etc. A youth and friendly look of the clinic could be an important aspect in inducing a non-tensed and more relaxed status to the clients. Without large investments, minor things like putting posters on the walls, flowers or decorative plants or changing the insufficient artificial lights in some places could make significant differences in this regard. More light and more colors would give life to the clinics and make them more attractive for young clients, who would feel more comfortable and relaxed in that environment.

Other characteristics to be considered are:

- **placement of the clinic in a discrete location**.

The youth concerns related to privacy and confidentiality were already described above, and their correspondent in the characteristics of a youth-friendly clinic is the availability of services, whenever possible, in discrete locations, where risks for being seen by other persons is minimum. Also, another concern of youth was waiting before the consultations in waiting rooms shared with other medical services. That was considered as a factor that increased the risk for being seen by known persons when using RH services.

- **female staff is preferred to male staff**

Probably because of education considerations, most girls said that they prefer and even would actively look for female RH providers. The reason for that is that they feel more comfortable with the idea of having (at least) the first ObGyn exam performed by a woman, and also that

they even feel like discussing easier on such issues with a person of the same sex. The female gender for a doctor is associated with a greater potential of being understanding and empathetic.

- **availability of other medical-related services**

Other medical-related services should be available in the same location (even if only in certain days/month), i.e. Pap smear, blood tests (including tests for STIs), abortions, dermato-venerological consultations. If it is not possible to provide these services in the same location, existing links with friendly-clinics or physicians that provide them have to exist. The reason for this is that adolescents might need sometimes tests or exams or other medical services; if they became already clients of the clinic, it would be easier for them -both psychologically and physically - to benefit of more services in the same place. If this is not possible, a recommendation from the staff in the youth-friendly clinic, towards other medical specialties' providers, represents a guarantee to the client, that those services are very likely to be just as friendly as those provided in the youth-friendly clinic, and he has not to fear for judgmental or disrespectful attitudes.

- **link with other non-medical services** (psychological counseling, legal medicine, police, etc)

Just as in the previous situation, the young clients might have even other non-medical related problems. Once they get to trust the staff in a youth-friendly clinic, some of these problems may show up, and the staff has to be instructed on how they might help the adolescent or young person in need. In some cases, affective disorders or other psychological matters could be in discussion and a strong relationship with a good counselor on youth problems is for sure a necessity for any RH clinic focused on youth. Another issues that have to be considered are those with legal implications, physical abuses being probably the most important one. The clinic's staff should have a standard of intervention in such situations, and definitely connections with the legal institutions that should be involved.

- **low costs**

Considering the limited financial resources of youth, the lowest the costs of the medical services are, the larger would be the group of youth who could access them. From a different perspective, each clinic has to cover its expenses. Therefore, depending on the clinic's type (public, private, owned by NGOs) and on the legislative regulations financial system, etc. (which probably will be also modified in the future), different solutions and prizes could be in place. It would be probably useful to accomplish a preliminary analysis of the differences in the legal and financial regulations that exist between different types of clinics, and to identify the most appropriate solutions for placing and financing youth-friendly clinics.

- **availability of contraceptive methods at low costs, or if possible - free of charge.**

For the same considerations as above, the existence of low-cost or, whenever possible, free of charge contraceptives would represent a motivation for youth to access the clinic.

- **informative materials available (posters, brochures)**

Informative materials should be available in the clinic and, if possible, they should have a non-traditional design and writing-style. No matter if the period spent in the waiting room is shorter or longer, the adolescents consider that the availability of informative materials in that space is important and could be an effective way to increase your knowledge in the area of RH. Posters are easier to read and also contribute to a friendlier look of the clinic, while a brochure contains more information. Ideally, brochures on different topics should be available to take at home with you, since they might represent a reliable source of information later. The design of the materials should be non-formal, colored, funny, full of life. Also, the writing style of the brochures should be non-patronizing, warm, personalized, and not in a case using medical language. The use of video-materials could represent an excellent and successful educative tool, whenever available.

- **involvement of male partners**

The males should represent a group of special importance for a youth-friendly clinic. Some of the considerations in the previous parts of this chapter stressed on the importance of partner's opinions and attitudes related to protected sex and use of medical services, for the attitudes and behaviors of the girl herself. As revealed by other studies (RRHS 1999), this is very much true especially for women with a lower educational and socio-economic status, but all categories of young women could benefit of an attempt to make men more responsible for the RH of the couple. Counseling sessions with both partners in a couple or special sessions with men alone could represent possibilities to involve them more. Different channels to attract them to the clinic may be used: special "prizes" for the couples who come together at the clinic, postal cards/ brochures specially designed for men (in an attractive and funny way) to be given during the consultation to each girl to be further handled to their partners, funny posters outside the clinic inviting men inside for "a short session in RH", etc.

7. CONCLUSIONS

1. There is a real and increasing **need** among youth, especially adolescents, **for information and services in RH**. The age for first sexual intercourse is decreasing; only 26% of Romanian adolescents used a modern contraceptive method (22% used condoms) by the time of their first intercourse, while 31% used a modern contraceptive method by the time of their last sexual contact (RRHS 1999).
2. Youth **access to correct information is limited**.
3. **Communication on RH and sexuality issues between youth and adults is often very limited.**
4. The general perceived attitude of adults is that **sexual activity in adolescence and early youth is not appropriate.**
5. **Adolescence** is a time of becoming and self-searching that might **involve risk-taking, low self-esteem and vulnerability.**
6. The **sexual debut could be a difficult decision and usually a not-informed one**; adolescent girls are generally not used to make decisions on their own, including analysis of the situation and assuming the responsibilities involved by this act. The lack of communication and support in this regard leads to lack of physical protection and psychological tensions.
7. **Adolescents who start their sexual life earlier** are usually **more independent, but less informed** than the girls who start their sexual life later.
8. Adolescents' **feelings and emotions are more "colored" and powerful** than those adults experience**.**
9. The **existing FP and RH services are not promoted at all to adolescents and youth**. The link between information and services should be increased.
10. Young women **avoid addressing their school doctors**. Usually adolescents prefer to go to a private FP or ObGyn clinic, or to a GP.
11. The most "**pleasant**" experiences related to RH services were considered the **FP clinics**, although adolescents may go as well to an ObGyn for their first consultation in RH.
12. The **main barriers** that were identified as limiting youth access to RH services are **psychological**. Usually adolescent girls fear that first visit to a FP/ObGyn doctor, explained through:
    - **fear of the gynecological exam and procedures;** this issue was by far the most important barrier identified in the quantitative component.
    - concerns related to potential judgmental and critical attitudes from the medical staff, due mainly to the fact that she has started her sexual life;
    - concerns related to potential lack of respect;
    - shame and discomfort in discussing about RH issues;
    - small degree of fear that, after all, when you are consulted by a doctor, a "hidden illness" might be discovered;

- fear of being "desconspired": lack of confidentiality regarding her sexual activity from the clinic staff, the possibility to be seen by parents, friends of parents, relatives, while entering, waiting or leaving the clinic;
- Negative implication of friends, especially of the partner.

13. **Other barriers** that limit youth access to RH services, that were identified through the present study are:

- lack of information regarding contraception, FP services and RH in generally;
- lack of information related to the importance of use, and availability of medical RH services;
- lack of communication on these issues with informed and trustable persons (family, teachers, other relatives);
- low awareness of risks involved by unprotected sexual intercourse.

14. The first **three most-important characteristics of a RH service**, from the youth perspective are (listed in order of importance):

- empathetic, kind, warm, patience staff, able to listen and answer to all the client's questions and to treat his patient with respect
- staff with good professional skills
- pleasant environment (funny, colored, designed in a youth manner)

15. **Other characteristics** to be considered are:
- placement of the clinic in a discrete location; also, the existence of a private waiting room, if other medical services are available in the same building;
- female staff is preferred to male staff;
- availability of other medical-related services in the same location (even if only in certain days/month), i.e. Pap-smear, blood-tests (including tests for STIs), abortions, dermato-venerological consultations; if this is not possible, existing links with friendly-clinics that provide these services;
- link with other non-medical services (psychological counseling, legal medicine, police, etc);
- low costs;
- availability of contraceptive methods at low costs, or if possible - free of charge;
- informative materials available (posters, brochures), if possible having a non-traditional design and writing-style;
- involvement of male partners.

16. The **most important element to consider when designing RH services is selection and training of the staff** in working with youth.

17. A **curriculum for training the providers** on how to deliver RH services to young clients should **focus mainly on building the providers' attitudes and abilities in working with youth**. The content of the curriculum should also be modular and flexible, in order to be easily used for training different types of providers (FP doctors, ObGyn specialists,

nurses, etc).

18. Other critical issue is **the image of these services and the promotion of that image to young clients**. Promoting a youth-friendly image of a clinic might be important in fighting back the above-mentioned fears and, of course, the lack of adressability to medical RH services. In the promotion process, it should be highlighted that the clinic offers special services for youth, at low costs, along with stressing on the empathy of the staff, explaining what the medical consultation and exam would consist of and the possibility of not doing a pelvic exam if the client does not want it at the first visit.

19. A strategic element that would be useful for this is **creating a youth (funny, colored, etc), trustable and friendly symbol and slogan for all the clinics** that offer this “quality” of services (FP cabinets, ObGyn cabinets, possible GP cabinets). This created image should help overcoming some psychological barriers identified, involved in generating the feeling of fear.

20. **Messages** to be used for promoting the services to youth should be in the spirit of the following: "Trust us". "There is nothing to fear of". "Everybody does it, important is to do it protected". "We are here to help, not to judge". "We are your friends".

21.RECOMMENDATIONS

1.**Development of reproductive health services that are more adequate to youth needs** is recommended.

2.It is also recommended to **strengthen the link between education and the promotion of RH medical services.** In this regard, it is recommended to include within formal RH educational programs, a module/theme/class aiming to educate youth to address existing RH services, even before deciding to become sexually active.

3.Since confidentiality and intimacy are important concerns for young persons, especially adolescents, from the RH and FP services available now in Romania, the most suitable to match their needs in this moment are existing **individual FP cabinets**. Therefore, it is recommended to consider **placing youth-friendly services firs**t within this type of units. Ionly if this is not possible, other types of FP facilities should be considered, but all the efforts toward insuring privacy have to be made (i.e.: separate enters, separate waiting room, etc).

4.An **analysis of the differences in legal regulations, logistics and financial regulations** between the private, public and non-governmental clinics that provide RH services has to be done, before deciding the best alternative for placing youth-friendly clinics, from all the perspectives.

5.The recommended **characteristics of a youth-friendly clinic** are: discrete location, confidentiality, friendly and professional staff, friendly environment, links with other medical services (ideally at least some the services are available in the clinic, at least in several specific days/month) and also with non-medical services (psychological counseling, legal medicine, police, etc.), low costs (including availability of contraceptive methods at low costs/ free of charge), informative materials available, involvement of the male partners.

6.The **characteristics** that a **youth-friendly provider** is recommended to have are: communication abilities (including the ability to listen), empathy, warmness, patience, respect for his clients and professionalism. All these qualities have to be native and/or improved through the training course.

7.A **training curriculum** on how to deliver RH services to young clients is recommended to be elaborated, as a first step in the process of developing youth friendly services in Romania. The focus of the curriculum has to be on building the providers' attitudes and abilities in working with youth. The results of this study could be used, within the curriculum, to make the providers understand how youth perceive the services they benefit of. Obviously, the course has to have also a medical component. The content of the curriculum should be modular and flexible, in order to be easily adapted for training different types of providers (FP doctors, ObGyn specialists, nurses, etc).

8.Besides the quality of services, another important element for the success of such an initiative is **promoting the created services to youth**. In the promotion process, it is recommended to highlight that the clinic offers special services for youth, at low costs, along with stressing on the empathy of the staff, explaining what the medical consultation and exam would consist of and the possibility of not doing a pelvic exam if the client does not want it at the first visit.

9. A strategic element that is recommended to be used for this is creating a youth (funny, colored, etc), trustable and friendly **symbol/logo and slogan for all the clinics** that offer this type of services. This created image should help overcoming some psychological barriers identified, involved in generating the feeling of fear. Messages recommended to be used should be in the spirit of the following: "Trust us". "There is nothing to fear of". "Everybody does it, important is to do it protected". "We are here to help, not to judge". "We are your friends". The created image has to be identified with all the places that offer youth-friendly RH services (FP cabinets, ObGyn cabinets, possible GP cabinets).

10. All the aspects that involve **creative processes** (design of the logo and slogan, development of posters and brochures, decoration of the clinic, etc) **should consider the psychological particularities of this age and involve youth in the creation act**.

8.PROPOSED MODEL FOR DEVELOPING YOUTH FRIENDLY SERVICES

1.Ideally, for increasing the quality of services for youth, all FP and ObGyn providers should be able to offer appropriate services to youth, at least in terms of competence, empathy, confidentiality and privacy. In practice, **each district in Romania should have at least one clinic** that targets youth and is able to offer youth-friendly services.

2.The clinics that will offer youth friendly services will be selected from **existing FP clinics**; the ideal profile of a candidate FP clinic is: to have young, competent and sympathetic staff, to be placed in a private, discrete office/ location.

3.An important aspect for the psychological and physical comfort of the patient is the gynecological exam (including the doctor-patient relation: the way the doctor helps the patient to relax, to overcome her feeling of "shame", etc). Training/ workshops with **ObGyn providers** on this theme, articles in ObGyn magazines, and other means could be used within a more elaborated intervention strategy, aimed to change the actual physicians' attitudes and behaviors into more client-oriented ones.

4.The most critical factor for successful youth services is the **staff.** The personnel should be competent but also non-judgmental and empathetic, able to assure the privacy and confidentiality of clients.

5.Therefore, the training of medical staff in the clinics willing to offer youth-friendly services is an essential component in the effort of designing such services. The training course has to be much more focused on changing staff attitudes, than on improving their medical knowledge.

6.**Motivation of the staff** is also a critical factor for the success of the program. It would be desirable to identify and use as many issues that might be of impact in this regard, as possible.

7.Other critical issue is **the image of these services and the promotion of that image to young clients**. Young girls usually associate the first visit to a RH medical service (either FP or ObGyn) with a very acute feeling of fear; therefore, they usually postpone and delay their first visit to such services, even if their level of education is high. The most important barriers are the fear of medical staff (judgmental and severe), the fear of non-confidentiality and the fear (and shame) of medical exams (first ObGyn exam) that they consider are obliged to go through. Promoting a youth-friendly image of a clinic might be important in fighting back the above-mentioned fears and, of course, the lack of adressability to medical RH services. In the promotion process, it should be highlighted that the clinic offers special services for youth, at low costs, along with stressing on the empathy of the staff, explaining what the medical consultation and exam would consist of and the possibility of not doing a pelvic exam if the client does not want it at the first visit.

8.A strategic element to be used for promoting the clinics is creating a youth (funny, colored, etc), trustable and friendly **symbol/logo and slogan** for all the clinics that offer this type of services. This created image should help overcoming some psychological barriers identified, involved in generating the feeling of fear. **Messages** recommended to

be used should be in the spirit of the following: "Trust us". "There is nothing to fear of". "Everybody does it, important is to do it protected". "We are here to help, not to judge". "We are your friends". The created image has to be identified with all the places that offer youth-friendly RH services (FP cabinets, ObGyn cabinets, possible GP cabinets) and also used on presentation and promotional materials.

9. Having the same identity, practically all the youth-friendly clinics in the country will be linked into a **national network** with a very clear identity, that might be promoted easier. In the same time, being part of a network might represent for the medical providers a motivational implication and, depending on the way the network is run, access to other facilities (easier information on youth matters through an internet connection, easier access to funds, etc).

10. Young people need a **variety of RH services**, which could be only in part assured by existing family planning clinics. Besides contraceptive assistance and supply, access to psychological counseling and to youth-friendly ObGyn (especially for first ObGyn consult and safe abortions) and dermato-venerological medical services should be insured through the youth-friendly clinics (if possible in the same facility; if not through a referral system). The youth-friendly clinic should be also able to direct its young client to any other non-medical services that might be of help (for example legal and social assistance in case of sexual or physical abuses).

11. After developing the training curriculum and the concrete workplan, the program has to be **piloted** in several selected clinics in Romania, and after that expended to all the districts.

12. A **monitoring and evaluation** system will be designed in order to have the feed-back from the youth clients we target and to adjust the program accordingly. Time-to-time interviews with the clinics' clients/ client-satisfaction questionnaires represent the most suitable options. The evaluation would also allow understanding how local distinct particularities of clinics (i.e. in district X the youth-clinic offers access to Papanicolau exams on the second Wednesday each month) make a difference in client satisfaction. It would also allow identification of good-practice models and their dissemination.

10. ANNEXES

10.1 THE QUESTIONNAIRE USED IN THE QUANTITATIVE COMPONENT

Introduction: the following questions refer to existing family planning services. Your answers and opinions in this matter are important for us, since we would very much like to improve the quality of the services available for youth. Please consider the fact that there are no good or wrong answers, what is important is honesty. We also assure you of the full confidentiality of your answers - and one guarantee for this is the fact that you are kindly requested NOT TO WRITE YOUR NAME in any place on the questionnaire.

Please try to answer to all the questions below:
1.Year of birth:_____

2.Gender:

1. Female 2. Male

3.Some places where people could benefit of family planning services are presented below. If you needed such services, where do you think you would go for help? *(please consider all the locations mentioned, and note **all of them** with one mark from 1 to 6. Each of these 6 marks has to be given only once. 1 is the mark for the location you would go in the first place, while 6 is the mark for the less desirable location):*

__ Family doctor cabinet

__ Family planning cabinet, located in a hospital

__ Family planning cabinet, located in a policlinics

__ Family planning cabinet, with its own location

__ School medical cabinet

__ Other situations (please specify)_____

4.Which from the following reasons for not addressing family planning services, you consider important for youth *(please mark your option for each line, by putting an X in the corresponding cell):*

	Not important at all	***Not important***	***Rather important***	***Important***	***Very important***
Not having a sexual life yet					
Disapproving public opinion					
Medical staff attitudes/ behaviors					
Costs of medical services					
Only married people need family planning					
Parents, parents' friends, relatives, etc might see you when going to such services					
Shame/ fear of the gynecological consultation					
Price of the contraceptive methods					
Use of traditional contraceptive methods (i. e. rhythm)					
Other reasons*(please specify which)* _____ _____					

5. On your opinion, going to a family planning cabinet involves:

(Please select as many answers as you find appropriate, and mark them with an X in front of the answer)

__ Completing a questionnaire

__ Completing a medical form

__ General consultation

__ Gynecological exam

__ Useless questions

__ Counseling (an active dialogue between the doctor and the client)

__ Receiving a medical prescription for a certain contraceptive method

__ Others *(please specify which)* _____

6. On your opinion who should go to a family planning service:

(Please select as many answers as you find appropriate, and mark them with an X in front of the answer)

__ Married women

__ Couples

__ Girls who started their sexual life

__ Unmarried girls who think they might be pregnant

__ Girls who had an unwanted pregnancy in the past and want to avoid this situation

__ Women after giving birth

__ Girls and boys who want to get informed, although they are not sexually active

__ Both partners in a couple

__ Other categories *(please specify which)*: _____

10.2 THE INTERVIEW GUIDE USED IN THE QUALITATIVE COMPONENT

IN-DEPTH INTERVIEWS
KNOWLEDGE, OPPINIONS, ATTITUDES, BEHAVIORS ON THE USE OF MEDICAL RH SERVICES
YOUNG WOMEN, 15-24 YEARS OLD

INTRODUCTION

Good day. My name is ..... and I represent the Youth for Youth Foundation, Romanian NGO which is active in the field of health promotion and education for youth. In this very moment, our organization develops a study aimed to better understand the youth opinions and unmet needs in the field of reproductive health and services in Romania. We would be extremely grateful to you if you accept to be part of this study, by discussing with us for about 15-20 minutes, on the above mentioned topics.

The entire discussion will be confidential, therefore I will not ask you your name or other personal data (address, etc), except for your age. Also, you are absolutely free not to answer to the questions you may find to intimate or indiscreet.

Because this is a study, I would also like to ask for your permission to audio-tape our discussion. This is only for my ears, and would help me to focus more on our discussion, instead of taking notes - which I would do later, listening to the tapes.

TOPIC FOCUS	*CORE QUESTIONS*	*ADDITIONAL QUESTIONS OR PROMPTS*
Knowledge on the existence of RH services.	Could you tell me what places you know where young people like you could go and discuss with specialists about their personal life, sex, contraceptive methods, STIs, etc?	• How did you find out about these services? • What types of services did come to your mind when I asked his question? (psychological counseling, family doctors, school doctors, etc)
Personal use of services	Have you ever used RH medical services? *If yes - the interview continues with the upcoming module of questions* *If not - the interview continues with module 4*	

TOPIC FOCUS	*CORE QUESTIONS*	*ADDITIONAL QUESTIONS OR PROMPTS*
First visit and the followings, to a medical clinic that offers RH services (for persons who have ever used this type of services) *The following types of facilities are kept in mind to be checked:* *ObGyn specialist/ cabinet for consultation, abortion, pregnancy, etc.* *FP cabinet/ doctors* *Family doctors* *Dermato-venerologist cabinets/ specialists*	Could you tell me about the first time you have ever been to a clinic offering RH services? Have you ever used again the same type of services? What about other types? Could you tell me more about those experiences?	• Do you remember how old you were when you first went to such facilities? Were you sexually active by that time? • Which was the main reason for your visit to that clinic? Do you remember which were your main concerns by that time (related to your visit to the clinic)? How did you overcome those fears? • Had you ever discussed with anyone else about your intention of going to the clinic, prior to the visit? With whom? Had you receive any piece of advice? • Why did you choose to go that particular facility? (possible answers: recommended by a friend, discrete location, the only clinic she had ever heard about, publicity, the clinic hours, etc) • Do you remember how you had felt before going to the clinic? Were you scared/ nervous? • How long did the consultation last for? Did you have to wait before being consulted by the doctor? For how long? Had you made an appointment for it? Have you ever made appointments for this kind of visits? • Was there any particular issue that you felt unhappy with or that made you feel bad enough not to ever come back to that clinic? • Was there any particular issue that impressed you in a pleasant way, during that first visit? • Have you ever discussed with anybody about that experience? *If yes* - with whom? What did you tell her/him? *If no*t - why not? • Have you ever recommended that clinic/ that type of services to anyone else?
	The following issues will be discussed: • the professionalism of the clinic staff • the attitudes of staff	• Did the medical staff you discussed with seem competent to you? What did you discussed about? Do you remember some of the questions the doctor asked you? Do you remember what contraceptive methods he told you about? How did you reach the decision of using a certain contraceptive method? (informed choice, choice induced by the doctor, etc) What contraceptive method did you use and how did you get it? What medical exams (i.e. breast exam) were included in the consultation? Did

TOPIC FOCUS	*CORE QUESTIONS*	*ADDITIONAL QUESTIONS OR PROMPTS*
		you feel the need of asking questions for clarification some issues? If you asked questions, were you answered by the medical staff and in which way? Do you know your patient rights? If yes, do you think they were respected?
	location of services (geographical location, look of the clinic, clinic hours) • access to other types of RH services (ObGyn, dermato-venerologists, etc)	• Did you feel comfortable during the consultation and the medical exam? Were you scared? Were you embarrassed? Did you feel ashamed or did you feel that your intimacy was intruded during the exam? Were you afraid of anything? Of what and why o you think you felt that way? Was the staff attitude friendly, encouraging? Did you feel that you were respected during that visit? Did you feel like the consultation lasted long enough, or you would have liked it to last longer? Was it anything you would have liked to talk about with the doctor, but you did not have the courage to do it? If yes, why? Did you have, at any moment, the feeling that you were judged for using these services? If yes, which do you think was the reason? (age, the fact that you were not married, etc). Did you worry about the possible lack of confidentiality from the clinic staff? Could you tell me about any other issues that made you feel uncomfortable or comfortable during your visit to the clinic?
		• Did you like the way the clinic was decorated? How important was that detail for the way you felt there? Were there any general factors in the way the clinics you had visited looked, (i.e. The color white, the furniture, etc) which you found stressful? Were there any informative materials exposed (brochures, posters, etc) How useful did you find those materials? Did you look through them? Did you find out new things by reading them? Did you wish there were more informative materials, on various topics?
		• Have you been sent to other linked RH services, with the occasion of your visit to FP cabinets?
• Module 4: Barriers in using FP services (for persons who have never used FP or other RH medical services)	• Which are the reasons for which youth do not address RH services? • The following possible barriers are kept in mind: • lack of the habit to address any type of medical services • lack of information • lack of responsibility/ easiness in taking risks	• Have you ever attended any type of medical services? Were those experiences pleasant or not? Why? • What do you understand through RH? What types of services (medical and non-medical) do you think might be included under this name? Do you think these services are/ should be different from other existing medical services? If yes, in which way? What do you think a FP consultation means and includes? • Where did you find out from, for the first time ever, about the existence of such services? Have you ever discussed with your friends about this? Have you ever seen on TV or heard on radio something on this theme? What about magazines, newspapers, school, family, etc? Which are the main ideas sent by mass-media on sexuality? What about RH and medical services? But in the case of school/ family? How knowledgeable do you feel about sexual matters? But about RH matters? • Have you ever though you might have needed RH services? Have you ever thought to use these services? *If not* - why not? *If yes* - why didn't you use them? Do you think you have ever been exposed to the risk of getting pregnant? What about the

TOPIC FOCUS	*CORE QUESTIONS*	*ADDITIONAL QUESTIONS OR PROMPTS*
	• fear of .... • staff attitudes/ lack of confidentiality	risk of getting an STI? Why? Do you remember fearing in those moments that something like this could happen to you? What did you feel/ think/ do in those moments? Did you discuss with anybody about this? With whom? What advice did you receive? • Which do you think your emotional would be right now, if you knew you would attend tomorrow a FP consultation? Why would you feel that way? • Do you know anybody who has ever used this type of services? Did she/he tell you more about her/ his experience? What do you remember she/ he told you?
• Youth- friendly RH services	• Which is your general opinion on the existing RH services? • How would you like the RH services to be, for you to feel comfortable using them?	• In this very moment, would you rather say that existing RH services in Romania are friendly, trustable, pleasant? Why, Why not? • Do you think these services meet the needs of young clients? Which do you think the main characteristics of these facilities should be, in order to really attract youth? • Do you think RH services should address men also, or they should be designed for women only? Why? • Which do you think is the most appropriate way for you to be persuaded to use these services? I would like you to think and tell me three words you think might kept your attention, if hearing them in an advertise for this type of services. •