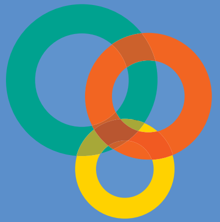

STRATEGY

FOR YOUTH DEVELOPMENT AND HEALTH IN THE REPUBLIC OF SERBIA

Ministry of Health
of the Republic of Serbia

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2006

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Preface

Good health of young people and adolescents' is extremely important. It is important for young people as much as it is important for the country. Without good health young people cannot reach their potentials, and the country cannot develop. Therefore, it is a challenge for the society to improve health of young people and the health care system.

The Ministry of the Republic of Serbia has shown its dedication to preservation and improvement of young people's health, through the health policies, and through health care expenditures targeting this vulnerable group of population. In the end of 2003, the Expert Group for Young People's Development and Health was established. One of its tasks was to create the National Strategy for Youth Development and Health. UNICEF's expertise and support in preparation and development of the document was valuable, as UNICEF is a strategic partner of the Ministry of Health in care for young people and improvement of health care services intended for children and adolescents.

Many months of dialogues and discussions with young people, GO and NGO sector, institutions and services for young people resulted in the National Strategy for Young People's Health and Development. The Strategy represents the widely achieved consensus on objectives for improvement of young people's health and necessary adjustments of the health care system. At the same time, the Strategy is an instrument for mobilization of not only the health sector, but also all stakeholders within the society – as partners in the preservation of young people's health, solving their problems and preventing them from engaging in unnecessary risks. The Strategy key orientation is promotion of young people's health and primary prevention, development of partnerships and strengthening the legal regulations in this field.

By adopting the Strategy in November 2006 the Government of Serbia expressed the clear orientation towards the young, as vulnerable population group, who were recognized as the national priority. The Government did not only adopt a significant political document, but also an action plan with an intention to give the real meaning to the political orientation. The Strategy insists that politics should be followed by the practical measures and results oriented activities. This means new ways of work and forming new partnerships through national endeavors to develop young people's health and build the contemporary system of health care.

Professor dr Snezana Simic
Assistant to the Minister of Health

Gratitude

Special thanks to the UNICEF office in Belgrade, the strategic partner of the Ministry of Health of the Republic of Serbia, for support and advice during the preparation of this document.

Young people are not the source of a problem – they represent resources needed for its solving

UN General Assembly, May 2002

WHY A NATIONAL STRATEGY FOR YOUTH DEVELOPMENT AND HEALTH

There are several reasons for preparation of a National strategy for youth development and health:

1. Adolescence is a period of change and experimentation. Habits and ways of living established in that period have a far-reaching influence on future health and development. It is estimated that 70% of premature deaths among the adult population are largely caused by behaviour during adolescence. Many ways of behaviour started with during adolescence, such as unprotected sex and abuse of addictive substances, may provoke HIV transmission, may cause unwanted pregnancy or sexually transmitted infections, as well as addiction.

2. Young people are an important resource for the future. Their health and development should be invested in in order for them to become capable of fully participating and contributing to society.

3. Young people have rights – the right to information; availability and accessibility to health and other services; the right to privacy, confidentiality, dignified behaviour and respect; treatment by trained and professional persons; a healthy and safe environment.

4. Young people have the right to participate in decisions and activities that influence their lives, as well as to take part and have opinions which befit responsible citizens.

5. The service for youth is different to the service for adults, because, when young people are in question, we should emphasise information more, psychological and social support, as well as promotion and preventive health services.

Pursuant to Article 45, Paragraph 1 of the Law on Government
(*Official Gazette of the Republic of Serbia*, no. 55/05
and 71/05 – correction),

The Government issues the following

STRATEGY FOR YOUTH DEVELOPMENT AND HEALTH IN THE REPUBLIC OF SERBIA

2007–2012.

1 INTRODUCTION

At the end of 2003, the Ministry of Health established a Expert group for youth development and health, following, among others, one of the leading principles in the vision of the healthcare system in the Republic of Serbia. This principle emphasizes that special attention will be given to initiatives that will improve the protection and promotion of children and youth health. One of the tasks of this working group is to develop a Strategy for youth development and health in the Republic of Serbia. During the preparation of this document, UNICEF, as a strategic partner of the Ministry of Health, provided professional assistance and support.

The Strategy for youth development and health in the Republic of Serbia (hereafter referred to as: the "Strategy"), as a document of national importance, is part of the overall strategy for healthcare system development. However, it also represents an instrument for the mobilisation not only of the healthcare sector, but of all society factors, as partners in youth healthcare, solving problems and prevention of behaviour that poses a health risk.

The Strategy includes aims, activities and expected results of youth health promotion, including the preparation of young people to care for their own health as well. It also implies the improvement of quality, efficiency and accessibility of healthcare, as well as finding new approaches for improving young people's health.

The key guidelines of the Strategy are youth health promotion and primary prevention, as well as the development of partnership relations and strengthening of legislature. The Strategy underlines the need to provide all young people with a set of healthcare services that are confidential and high-quality, based on youth needs, and provided by motivated, friendly and educated health professionals in a safe environment, where young people will have a key role in planning, implementation, monitoring and evaluation. Special emphasis has been placed on overcoming the health challenges faced by young people who are already in an unfavourable social and economic position. Team work between the sectors is important

for youth health and development, and should be the way for creating such an environment in which all young people will have conditions ensuring physical and mental health, psychological and emotional wellbeing, freedom from abuse and exploitation, as well as the knowledge and opportunity to lead a healthy life.

The Strategy is founded on the basic principles and values emphasized in international documents in the field of public health, and child and youth health promotion, such as, *The UN Convention on the Rights of the Child*, *UN Millennium Development Goals*, *A World Fit for Children*, *Quality Education for All*, *Health for All in 21st Century*, *Plan of Action for Environment and Children's Health in Europe*, *Fifth Conference on Population and Development (Cairo, 1994)*, *Sexual and Reproductive Health Strategy of World Health Organisation* (hereinafter: "WHO"), etc. According to its content, this Strategy relies on existing national strategies: the Poverty Reduction Strategy Paper, the National Plan of Action for Children, the National Strategy for the Fight Against HIV/AIDS, and the National Mental Health Strategy.

Main guidelines of the Strategy:

- establishment of national priorities in the field of youth health;
- creation of activities in the area of health promotion – especially those for which young people are responsible;
- to move the focus of activities from diseases to health determinants and risk factors as causes of illness and premature death;
- promotion and support of individual and collective healthy lifestyles, adequate healthcare and social services and effective use of healthcare services;
- development of partnership with young people;
- defining indicators for monitoring health determinants and risk factors related to youth health.

The Strategy identifies:

- directions of services and sector development included in youth health promotion;
- desired outcomes pursuant to established objectives that should be realised through activities of all society subjects;
- areas where coordination between healthcare and other sectors is needed in order to achieve the set objectives;
- main responsible entities at republic and local levels that contribute to more justified resource utilisation by enabling inter-sectoral cooperation and coordination.

2 DEFINITION OF POPULATION

According to the UN definition, young people are the future of every society and they are the best long-term investment.

According to WHO data, adolescents are persons aged between 10 and 19; and young people aged 15 to 24 fall into the youth group. These two partially overlapping age groups are a complex grouping of young people between 10 and 24 years of age. Pursuant to the 1995 *Law on Healthcare* of the Republic of Serbia, among the population groups *"exposed to a higher risk of falling ill"* are also *"children aged up to 15, school children, and students up to the end of regular education, but only up to 26 years of age"*.

Observed in this way, according to the legal regulations of the Republic of Serbia, young people aged 10 to 26 are the target group of this Strategy, and it is necessary to take into consideration specific characteristics related to age intervals, i.e. development periods. Accordingly, two population groups are implied in particular: a) young people up to the age of 18, i.e. until the end of secondary school education, and b) young people aged 19 and over.

The age interval between 10 and 26 years of age, as a transition from childhood to maturity where the privileges of a child are lost and the rights and obligations of an adult are gained, is marked by profound changes related to biological development, sexual, cognitive, emotional and psycho-social maturity. Accordingly, young people establish control over their life, make decisions and bear the consequences of their own decisions and behaviour. In other words, habits and the way of life formed in youth have a far-reaching effect on the development, health and overall life of an adult person.

Therefore, through the implementation of the Strategy, it is necessary to promptly and adequately assist the population group of the above age to progress from adolescence to full maturity in a healthy manner.

3 DEMOGRAPHIC DATA

According to the results of the census conducted in 2002, in the Republic of Serbia (excluding data on Kosovo and Metohija) there are around 7.5 million inhabitants in total. The average age of the population is 40.2 years. The age index in the Republic of Serbia in 1991 was 0.51, and in 2002 1.00, which points to the fact that the ageing of the population in the Republic of Serbia continues.

In 2002, in the Republic of Serbia, the life expectancy for women was 75 years and for men 69.7 years.

In terms of age, we can also see further movement towards an older population in the population structure. The percentage of the population aged 0 to 14 fell from 23.2% (1991) to 15.7% (2002), while the percentage of the population above 50 is still rising.

In the Republic of Serbia, population growth ranges from 11.5 and 15.6 per thousand in 1950, and turns into negative population growth in 1992. In the past few years, the negative population growth has continued.

In the period 1950-2002, the general fertility rate in the Republic of Serbia fell by 50% (from 109 to 47.4 per 1000 women of generative age). And while fertility is falling constantly, it is estimated, based on incomplete data, that the abortion rate per 1000 women of generative age is very high.

In 2002, in the Republic of Serbia (excluding Kosovo and Metohija), there were 1,447,910 young persons, as a population group aged from 10 to 24. Their percentage in the total population number is 19.31%.

In the Republic of Serbia, the percentage of illiterate aged between 10 and 19 in 1991 was 0.6%, and in 2002 0.75%.

In 2002, the number of marriages of persons aged 10 to 19 was 529.

In 2002, in the Republic of Serbia there were changes of abode – 15,861 young people aged between 10 and 14, and. 46,518 aged 15 to 24 respectively, migrated.

Young people are in the above average poverty risk category (12.7% of young people in this age group are poor). Their relative poverty risk is 20% higher compared to that of the average population.

The last decade of the 20th century can be termed as a period of “forced extended youth”, owing to which more than two thirds of young people became part of the “brain drain”, i.e. the permanent exodus of educated young people from our country.

The analysis of the status of young people shows that over 50% of employed youth, or over 70% of those unemployed, live with their parents.

Most young people, around 75% of them, believe that their families’ financial situation worsened considerably during the nineties, and classify their families among households that can satisfy the basic needs: food and clothing.

Their poverty is related to the fact that the process of young people acquiring independence has slowed down. The individualisation process is slow owing to a lack of basic resources: jobs, housings, and financial resources. Such a situation can also be explained if our culture is taken into consideration, since it is characterised by the domination of active family values and the slow transition to adulthood.

4 BASIC CHARACTERISTICS OF YOUTH HEALTH STATUS

According to the official statistical data on health, out of all population groups, the lowest disease rate and mortality rate are registered among youth groups.

However, the latest research in Serbia (UNICEF, WHO, UNFPA) indicate that there is a generation of young people whose health is endangered. Results of this research show that the leading health risks are increasing abuse of tobacco, alcohol, narcotics, and a high level of injuries (trafficaccidents, neglect and abuse). Also, the health status of young people is characterised by poor mental health with an increasing rate of behavioural disorders, dependence diseases, depression and suicides, as well as a low rate of contraception use with an increase in sexually transmitted infections.

The population's health culture is at a low level in general, and young people are not accustomed to protecting their health or having regular check-ups, and they do not have healthy lifestyles or take responsibility for their own health. They usually see a doctor after the appearance of some discomforts that can point to some disorders. The problems of discrimination, taboo and prejudice are still very serious, and if a young person takes care of his/her health, it is usually due to the fact that he/she is already sick, infected, etc.

Particular problems in satisfying specific needs are experienced by:

a) Young people with disabilities – They constantly come across architectural and information barriers, as well as stigma and prejudice, and the healthcare service and preventive activities are usually not available to them in a way that would satisfy their needs. The school environment and other places where young people gather do not give young people with disabilities an opportunity to develop and show their capacities and abilities.

b) Particularly sensitive, marginalized and socially disadvantaged youth groups – This group consists of the following: young people without parental care, the homeless, those placed in correctional institutions, the poor, those who are not included in the school system, members of national and religious minorities, young people who need special support, refugees and IDPs. The healthcare service has not yet fully developed targeted interventions.

Currently, the most serious health problems for young people in our environment – problems that require organised and continued action in order to be solved – are as follows:

4.1 Developmental and Psychological Problems

Adolescence is characterised by numerous – often noticeable – developmental and psychological characteristics, as well as psychopathological ones.

Clinical experience and the results of conducted research point to significant psychological suffering among the youth population. Around one third of secondary school and college students belong to the borderline and risk group, i.e. they show signs of psychological suffering, mental problems and disturbances, and they express their need for organised psychological and psychiatric support and/or assistance. Girls and adolescents in urban areas are more vulnerable.

With each passing year, there is an increasing number of young people that have psychological problems, or demonstrate certain, for this age, specific psychopathology, i.e:

- different difficulties of the adolescent process, focussed around forming a stable and definitive identity
- depression (including suicides) and behavioural disorders (including abuse of psychoactive substances, violent and delinquent behaviour and eating disorders).

It often happens that – during routine examinations and conversations – doctors, teachers and parents do not recognise signs of depression and suicidal ideas.

4.2 Reproductive Health Problems

Young people in the Republic of Serbia are a population category that is exposed to special risk factors that could lead to reproductive health damage.

4.2.1 Sexual activity

According to numerous studies, frequency of sexual activities among the young population in Serbia is increasing. It is shown through the increasingly large percentage of sexually active persons in the youth population, and the increase in the frequency of sexual activities among younger adolescents (up to 15), in particular among females of this age group.

The results of research conducted in 30 towns in the Republic of Serbia among students aged 11 to 15 have shown that 22.5% boys and 3.5% girls have had sexual relations. The representative poll among students of all university centres in the Republic of Serbia has shown that around three-quarters of students and over half of female students aged between 19 and 21 are sexually active.

According to data from a study that followed the changes in the sexual behaviour of second year female students at secondary schools in Novi Sad, only 2.2% had sexual relations in 1960, while that was the case with every fourth female secondary school student in the year 2000.

4.2.2 Adolescent pregnancies

According to estimates, during each calendar year there are around 50 pregnancies per 1000 girls aged 15–19. The size of this health and psychosocial problem in the Republic of Serbia is illustrated by the fact that in same age group in Holland there are 7 pregnancies, and 28 in Great Britain, a country that has the worst health state indicators of adolescent populations in Western Europe.

There is no reliable data on the scale of deliberate abortions. The exact situation is probably far more alarming compared to the one showed by official health statistic data. Based on results of smaller in-depth research, it is estimated that the number of recorded artificial abortions is considerably smaller than the actual number, despite the obligation to record such operations and to keep health statistics. This is supported by the fact that there is disharmony between the increase in sexual activity among young people, the unchanged scale of modern contraception use, and – according to the official data – the decrease in birth rate during adolescence.

The estimation is that, each year, around 6–7000 girls of adolescent age undergo such a medical procedure, and according to the results of smaller, in-depth research, every sixth girl from Belgrade who became sexually active during adolescence has experienced an unplanned pregnancy by the age of 19. It is known that with young nullipara a deliberate abortion is a significant predictor of miscarriages, premature births, and the development of infertility in later life.

Birth frequency in youth can be estimated by analysing specific fertility rates (number of women who gave birth per 1000 females of a certain age). By observing the changes in this indicator for the territory of the Republic of Serbia from 1950 until 2003, we can notice a fall in specific fertility rates with groups of older female adolescents, while in a group of 16-year-old girls it is at the same level, and in a group of 15-year-old girls it is even higher in 2003 compared to 1950. By analysing the reproductive behaviour model of the population of the Republic of Serbia, we notice an unfavourable trend that specific fertility rates among female adolescents stay relatively high compared to older age groups.

4.3 Sexually Transmitted Infections and HIV

For the time being, the extent of sexually transmitted infections among the young population in the Republic of Serbia is not known, which is a consequence of inadequate recording of these diseases and the impossibility of adequate diagnostics which would be available to most infected persons. However, results of a smaller number of studies conducted among sexually active adolescents show that a large number of the young population have one of the numerous sexually transmitted diseases. For example, in Belgrade the frequency of the genital infection Chlamydia in a group of 300 sexually active girls aged 19 is 30.3%, and it ranges from 18.7% – among adolescent females without discomforts – to 42.0% in a group of those experiencing genital infection symptoms.

HIV infection (and AIDS) represents only one of the sexually transmitted infections and diseases that creates problems for infected young people regarding social interaction, but it seems that it is the most noticeable.

In the Republic of Serbia, in the period from 1984 until the end of 2004, 1,908 persons infected with HIV were registered, out of which 1,245 are already ill. It is important to emphasise that the rate of HIV/AIDS cases in Belgrade is three times greater than that of the whole Republic of Serbia (excluding data on Kosovo and Metohija).

Out of the total number of registered HIV-positive cases, 1,388 are men and 520 women (sex ratio is 2.6:1) – out of whom there are 1,564 (82%) on the territory of Belgrade, while on territory of Vojvodina 186 HIV-infected persons (9.9%) are registered.

The HIV infection rate per one million inhabitants of the Republic of Serbia (excluding data on Kosovo and Metohija) per year of diagnosis indicates that there is a trend towards discrete increase. Under the age of 15, HIV infection is rare (3.6% out of the total number of those infected), and in the age range between 15 and 24 it is 4 times higher (13.2%).

According to transmission groups, there is a trend towards considerable decrease of HIV infection among intravenous drug addicts, haemophiliacs and blood and blood product recipients. On the other hand, there is a trend

towards considerable increase in the heterosexual and homo/bisexual groups. In the category of unknown – i.e. undetermined transmission (10.7%) – where most of those infected are male, there is a trend towards increase, which justifies the assumption that it is most probably a question of homosexual transmission, and additional efforts need to be made in order to destigmatise and educate this group.

Out of 1,245 persons with AIDS, 905 are men and 340 women (sex ratio is 2.7:1). According to territorial distribution, most AIDS cases occur on the territory of Belgrade (871 cases, i.e, 76%).

The majority of AIDS cases fall into the category of those aged between 15 and 49 (86.1%). Out of all those who have fallen ill, there are 5.3% of young people aged between 15 and 24, while falling ill under the age of 15 is extremely rare (2.8%).

Most AIDS cases are caused by blood transmission, which in most cases means the sharing of needles and syringes among intravenous drug users. There are 510 (41%) such cases. The second large group according to transmission is sexual transmission – both heterosexual and homo/bisexual. This relates almost completely to sexual relations without protection (condom), to promiscuous persons or partners of HIV-positive persons (473 cases or 38%). Besides these two groups, there is a significant number of those ill among persons for whom the method of transmission is not known (104 cases or 11%) or who are infected as blood or blood-products recipients (9%).

In the observed period, in the Republic of Serbia, 870 people are registered that died of AIDS (650 men and 220 women), and the sex ratio is 3:1. In Belgrade 629 people (73%) have died.

4.4 Addiction Diseases

Addiction diseases have a chronic flow and lead to severe psychological and physical health disorders among young people, and endanger or prevent normal psychological and physical development. Their social position and the position of their families is also extremely at risk, as is consequently that of their friends

Data related to the abuse of drugs/psychoactive substances (PAS) and addiction diseases in the Republic of Serbia is incomplete.

All research and polls conducted so far, although not methodologically unified, point to the following:

- increase in the percentage of psychoactive substances users among young people
- decrease in the age when young people come into contact with psychoactive substances for the first time
- increasing frequency of usage of two or more psychoactive substances together.

According to the official data, there is a constant trend towards increase in PAS abuse among young people. The age limits of people's first drug taking experience has moved significantly. The first experience happens, on average, around the age of 15, with a tendency towards further movement towards a younger age (in 1993, 0.7% belonged to the group of those aged between 15–19, and in 2002 and 2003 16.8% and 13.9% respectively). Frequently, drugs are first taken between the ages of 11 and 13. The substances used initially are mostly tobacco, alcohol, forms of cannabinoids, sedatives, individually or combined. Frequently, the initial drug is an opioid (especially among girls), and lately amphetamines too.

У адолесцентном периоду, најчешће се злоупотребљавају дуван, алкохол, марихуана, седативи, амфетамини („speed" и „ekstazi"), хероин, неки психофармаци (трамадол – Тродон, Синтрадон, Морадол, Артане, Акинетон и неки новији антидепресиви). Испарљиви растварачи In adolescence tobacco, alcohol, marijuana, sedatives, amphetamines ("speed"

and “ecstasy”), heroin and some psychotropic drugs (tramadol – Trodon, Sintradon; moradol, Artane, Akineton, and some new antidepression medicines) are mostly used. Evaporable solvents (glue, bronze) are abused less and less frequently. The use of other drugs is more sporadic, and there is a slight growth in the use of cocaine.

Among young people aged between 12 and 20, 8.4% have tried marijuana, 0.6% have tried ecstasy, 0.4% have tried cocaine, and 9.9% have expressed a wish to try a drug.

The number of young people who smoke is great: 54.7% of young people aged 13–15 have tried cigarettes. Passive smoking is extremely high and 97,4% of young people are considered to be exposed to smoking within the family. In the student population, 51.2% have tried cigarettes, 27% are active smokers, and 93.5% are exposed to passive smoking on a regular basis.

Among 11–15 year olds, 57% have tried alcohol, and 35% have had at least one drinking binge. In the student population, 96.5% have tried alcohol, and 71% of young men and 35% of girls have been drunk at least once.

4.5 Abuse and Neglect

Abuse and neglect, which have become socially visible, represent a big social problem that affects both young people who live in families and those who live in institutions for children without parental care and young people in vulnerable groups (persons who need special support, the Roma population, refugees and IDPs and other categories of those who are particularly vulnerable, marginalized and socially disadvantaged).

There is no unified data either at state or sectoral level regarding abuse frequency. Regardless of the area it covers (health, social work, police, judiciary), each institution treating victims of abuse has its own data.

A great number of organisations deal with this problem, but they also do not have a unified database. In addition, there is also a problem with unequal education and doctrinary positions in this area.

Young people are mostly abused in the family, but also in school, in public places, by peers and in institutions where persons with disabilities or young people in conflict with the law are placed.

The public's awareness of domestic violence is not sufficiently developed. The notion that family life is private and untouchable is still deeply rooted.

Several institutions at secondary and tertiary healthcare level have specialised teams for youth protection from abuse and neglect, i.e. experts educated to work in this area. However, co-ordination between them is not structured and formalised enough.

4.6 Injuries

Injuries to young people occur mostly in traffic, as a result of disregard of traffic regulations. Also, injuries occur at school, at home, on the sport fields, at meeting places of young people where adequate first aid is often missing.

Out of a total of 7,848 children aged 15–19 who were injured in Belgrade in 2004, 5,850 injuries were some other – specific, non-specific and multiple – injuries.

More and more often, injuries are due to physical abuse of young people, in the family as well at school and in the street, but there is no adequate data.

4.7 Physical Inactivity

Physical inactivity among young people may influence irregular body development and may help develop certain deformities and diseases. Among elementary school graduates, deformity of the spinal column is more frequent than among first-form pupils, which indicates that the condition aggravates during the eight-year education period.

Young people are faced with inappropriate or difficult conditions for taking part in sports or other forms of physical activity since there are no adequate fields and playgrounds, and the existing ones are often unsafe. Also, practicing a sport, especially professionally, often implies a large financial investment or a struggle to be in the first team. These are the most common reasons why young people do not go in for sports.

4.8 irregular Nutrition

Irregular nutrition represents unbalanced or insufficient food intake, and its direct consequences are growth and developmental disorders, appearance of illness (chronic non-infectious diseases, malnutrition, decline of the body's immune functions, and others).

Although food selection is individual and depends on the physiological needs of the organism, food consumption is still under the influence of cultural, social, economic and psychological life factors.

The influence of the environment and the wish to be attractive according to modern fashion trends, as well as the emphasis on extreme model-like slimness, often leads to improper nutrition and related consequences.

The lack of a nutrition culture, which implies a lack of knowledge of this area and wrong habits ("fast food", instant drinks, and similar) often negatively reflects on the state of young people's health.

There is no adequate and regular education on this issue.

4.9 Factors from the Environment Influencing the Development and Health of Young People

Among the most important from this group of factors, the following are singled out:

- disruption or collapse of the value system that makes it difficult for young people to structure their identity and makes them apathetic, which creates a space for the insertion of various negative things;
- schooling problems that additionally hinder the forming of young people's identity;
- increase in chauvinistic provocations;
- the problem of young people finding employment;
- poverty, as a reason for promiscuity in order to provide the bare necessities both of individuals and of the family;
- insufficient parental insight into the real needs of their children;
- alienation of family members, lack of communication, disintegration of the family;
- doctors do not have enough time for preventive work due to the underestimation of preventive work;
- lack of skills for team work.

5 ORGANISATION OF YOUTH SERVICES, LEGISLATION, RECORDS AND REPORTING

5.1 General Characteristics

Circumstances and potential problems of young people, are not sufficiently recognised by society or by families and individuals as well.

In the period 1968–1992, the Health Insurance Fund's – as it was then known – *Decision on Compulsory Types of Healthcare of Population*, had a significant contribution to youth healthcare promotion. Through its content and extremely preventive orientation, this Decision – through revisions and innovations – mainly applied the decisions of the famous *Alma-Ata Declaration on Primary Healthcare* (1978). The Decision formulated the obligation of the social community to provide each citizen, and each young person respectively, a certain level of healthcare as a guaranteed minimum.

After that period, on the basis of the 1992 *Law on Healthcare* (Article 7), the *Decree on Healthcare of Women, Children, School Children and Students* was adopted, and it is still in effect. The Decree has three separate programs – one of which is the *Program for Healthcare of School Children and Students* – and it was adopted by the Government of the Republic of Serbia in 1995. One year later (in 1996), the *Professional and Methodological Instruction for Implementing the Decree on Healthcare of Women, Children, School Children and Students* was adopted as well. Finally, in February 1998, the Government of the Republic of Serbia adopted the *Information on Family Planning*. A prepared manual for the education of health workers, entitled *Primary Healthcare of Mother and Child* (1997), was the last of many documents from that period. With the implementation of those documents, continuous post-graduate education of paediatricians, general practitioners and gynaecologists at the primary healthcare level began in the Republic of Serbia.

However, the greatest number of youth health needs is too complex to be independently resolved by a health service.

Although we know that, besides the health service, the family, school, local government and associations have a significant role in youth health promotion, that fact is not sufficiently used in practice. It especially relates to insufficient information on health, an absence of health education in the school system, and inappropriate involvement of society sectors other than that of healthcare (social wefare, education, means of information, etc).

In one of the waves of education reform (in the period 2001–2003), "health education" was recognised as an important part of the education process, and in that period it was combined with physical education (based on the fact that they are related), and turned into the subject known as "physical and health education".

Since the school year 2005/2006, "health education" has returned to the "old model" of drowning the health issues in a number of subjects (without a clear message, without an emphasised importance of health education, and without any idea or analysis of what has been done or what could be done regarding health education in this way).

Specific preventive programs, based on inter-sectoral cooperation, with young people's active participation are not sufficiently developed (the area of reproductive health is stated as a positive example of good practice).

5.2 Healthcare Organisation

The healthcare of young people is an integral part of the healthcare provided to the entire population. On the whole, the healthcare of the entire population is more oriented to treatment than to disease prevention and health promotion.

However, according to the aforementioned Decree and the *Program on Healthcare of Women, Children, School-children and Students*, the healthcare intended for young people has an emphasised health promotion approach,

aimed at reducing regional differences in health conditions, according to the following priorities: health promotion of adolescents of both sexes; development of humane relations between the sexes; responsible parenting, prevention, early detection and the treatment of all conditions that can have a negative influence on fertility, and a decrease in sexually transmitted infections.

The healthcare of young people – i.e. as defined, the population group aged 10 to 26 – is carried out, at the primary level, through the establishment of a health centre (Dom zdravlja), which is a basic, integral part of the healthcare system.

A. The healthcare of school children and young people other than university students, is implemented through the work of:

- a paediatric service, general practice, occupational medicine and gynaecology, a polyvalent visiting-nurse service in the health centre and satellite services in schools, students' homes, and similar.
- youth counselling services within healthcare services for school children, that apply a well-developed work model in the area of youth reproductive health; and some – with the application of model of active counselling work confirmed in practice – are starting to introduce other work contents.
- dispensaries for mental health are predominantly oriented to secondary prevention.

B. For the student population in university centres, primary healthcare is well organised and developed, as far as students of junior colleges and universities in Belgrade, Nis and Novi Sad are concerned. Healthcare is implemented through the health promotion service, general practice service, gynaecology, and mental health. For students in Kragujevac, healthcare is carried out at health centres.

At the secondary and tertiary levels, the health service in not particularly tailored for young people, and especially not for the population group of both sexes aged between 19 and 26. For 10 to 19-year olds, health services are provided at children's wards within general hospitals, children's clinics

and institutes for children and youth, certain specialised institutes, clinics and institutions. Young people over the age of 19, with the exclusion of exceptional cases, are treated and hospitalised with older patients in specialised departments within general hospitals, clinical and hospital centres, clinics and institutes, while special stationary healthcare is provided to Belgrade University students.

5.3 Specific Characteristics of Healthcare

Youth healthcare is not always adequate as far as organisation, availability and work methods are concerned. This problem is more present in rural areas, where healthcare is provided in reduced scope and content compared to the urban environment.

Specialists and general practitioners provide youth health services. Mostly they do not have enough specific knowledge and skills in the area of youth healthcare. Health workers and assistants are often not sufficiently acquainted with the nature of youth, so young people frequently encounter misunderstanding, criticism, and impoliteness.

In spite of good geographic diffusion and satisfactory availability respectively, the healthcare system is faced with inappropriate infrastructure, obsolete equipment and often cramped facilities.

Often, health services are not oriented towards young people and do not satisfy their specific needs and problems. Long queues and disrespect of confidentiality can discourage a young person from turning to and using healthcare services.

Medical records are available to others, so young people often cannot count on the confidentiality of information. Preventive talks and education oriented towards healthy lifestyles are often neglected or are totally absent. In most regions in the Republic of Serbia, there are no services intended for youth mental health, and rarely are there educated professionals to deal with the problems of youth mental health.

Young people need information, certain life skills and access to the services, which will help them to reach the age of full maturity in a healthy manner. Therefore, health workers need to be reoriented towards adolescents' health and development, and a wide range of experts (health and social workers, psychologists, teachers, police officers, etc), together with peer educators, need to develop an active approach, aimed at satisfying youth needs. This interdisciplinary approach, based on activities within the community, combines two complementary approaches: a) to provide each young individual with access to information and healthcare services; b) to provide targeted interventions to particularly vulnerable, marginalized and socially endangered groups of young people.

5.4 Legislation, Records and Reporting

In one part of the legislation, there are a number of laws and bylaws in different areas relevant to youth health (healthcare, environment, education, social welfare, traffic, financing and similar).

In the current situation, controversy between laws is present, with often unclear division of responsibilities. It actually means that, in many cases, it is not sufficiently clear who should do what and what should be financed by whom. Obligations in the area of youth development and health are not clearly defined among certain healthcare levels, or among other sectors. It is clear that this area is within the jurisdiction of several ministries: the Ministry of Health; the Ministry of Education and Sport; the Ministry of Labour, Employment and Social Policy; the Ministry of Science and Environmental Protection; the Ministry of Capital Investments; the Ministry of Justice; and the Ministry of Finance. However, the inter-sectoral approach to youth health is missing, as well as the active participation of young people in part of the preparation and adoption of legal regulations related to them.

The system of recording and reporting, which is also regulated by appropriate bylaws, does not provide an adequate procedure for generating huge amounts of data, in spite of a number of individual databases, whose accuracy, completeness, precision and validity are disputable. Consequently, such data cannot be adequately used in the decision-making process.

6 PRIORITY PROBLEMS

As priority problems, which must be solved by preventive and control measures – with the use of new technologies, development of inter-sectoral cooperation and partnership with young people – the following are underlined:

- open de-population, intensifying the process of the demographic ageing of the population and a decrease in the fertility rate;
- addiction diseases, malfunctioning of reproductive health and an increase in sexually transmitted infections and depression dominate when it comes to youth morbidity, while traffic accidents and other forms of violent deaths are registered as the leading cause of death;
- not recognising a healthy lifestyle as socially accepted behaviour; diffusion of forms of behaviour harmful to youth health, and insufficiently developed life skills at all stages of growing up;
- absence of health education in official primary and secondary school curriculums;
- complete access to targeted programs and to all programs and projects aimed at protecting and improving youth health is not available to young people with disabilities, or to the marginalized and socially disadvantaged;
- the Healthcare system infrastructure is not entirely satisfactory, and health workers are not sufficiently educated in the field of youth health promotion and life-quality improvement, and preventive activities are not valued sufficiently;
- poor teamwork, inter-sectoral cooperation and real youth participation in the area of health protection and promotion;
- lack of continuous, uniform and comprehensive monitoring of the state of health and behaviour of young people;
- insufficient sensitivity to creating conditions for equal gender opportunities.

7 STRATEGIC GOALS

Based on the data presented in the situation analysis and the stated priority problems, the following are established as Strategic goals:

- to promote healthy lifestyles and youth health protection and promotion;
- to achieve youth health equality regardless of differences relating to sex, health condition, socio-economic status, ethnic, religious or other affiliations;
- to re-direct healthcare from a clinical approach towards health promotion, inter-sectoral cooperation, including community, active youth participation and the development of individual health responsibility.

Strategic outcomes are defined in addition:

- at least 50% of young people to have adopted healthy life styles and to use adequate healthcare services;
- all young people to have equal opportunities to access information and to utilise healthcare services in order to protect, preserve and promote health, regardless of differences relating to sex, health condition, socio-economic status, ethnic, religious or other affiliations;
- healthcare system for young people to be available and youth "friendly" as regards the quality of operation – with regards to territory, contents and approach – with the full application of health promotion, team work development and inter-sectoral cooperation, active participation of young people and involvement of the local community;
- healthcare system for young people to be available, as regards the quality of operation – with regards to territory, contents and approach – to young people with disabilities, and to the marginalised and socially disadvantaged.

Strategic outcomes are monitored by a set of Strategic indicators:

- the prevalence of sexually transmitted infections (STI), HIV infection, birth among young adolescents, abortions, mental health disorders, suicides/ suicide attempts, violent behaviour on the part of young people, abuse of psychoactive substances among young people;
- the percentage of young people that believe they are protected against abuse and neglect, as well as the number of recorded/successfully solved cases of abuse and neglect;
- the percentage of young people that use healthcare services, both in terms of protection and health promotion and in terms of treatment;
- the prevalence of STI, HIV infection, abortions, birth among young adolescents, mental health disorders, suicides/ suicide attempts, violent behaviour on the part of young people, abuse of psychoactive substances among especially vulnerable, marginalised and socially endangered youth;
- the percentage of young people with disabilities, and marginalised and socially endangered young population that use healthcare services, both in terms of healthcare and promotion, and in terms of treatment;
- an established system of constant monitoring, evaluation and work quality promotion of healthcare services for the young population;
- the percentage of municipalities on the territory of the Republic of Serbia where services for youth healthcare exist with a verified work quality minimum;
- the percentage of municipalities on the territory of the Republic of Serbia where targeted interventions for the healthcare of especially vulnerable, marginalised and socially disadvantaged young people exist, with a verified work quality minimum.

The aforementioned indicators are obtained on the basis of vital and demographic statistics, routine healthcare statistics, and/or by conducting targeted research. They are monitored according to defined categories regarding sex, age group and other specific characteristics, with the aim of gaining as complex an insight as possible.

Strategic goals are further developed into a number of general and specific goals, whose implementation implies actual youth participation as a condition.

7.1 General and Specific Goals

7.1.1 To develop a safe and supportive environment for youth health and development

Expected general outcomes:

- at the level of the Republic of Serbia, the legally supported development of a safe environment for young people, with full participation of young people at all levels/in all sectors;
- systematic monitoring of youth development and health, with their full participation and cooperation at all levels/in all sectors;
- achieved inter-sectoral cooperation, strengthened capacities of all relevant factors, developed and implemented local plans of action for providing a supportive and safer environment for youth development and health at the local level, in at least 75% of municipalities.

General indicators:

- the existence of legal mechanisms and systematic mechanisms that regulate and protect children's human rights and youth health;
- the percentage of young people that believe their health and development is supported by republic and local authorities;
- the percentage of young people that believe that at republic and local levels their opinions are considered, and that they participate in the creation and implementation of health and development activities.

Data source:

- Government Report;
- research of youth attitudes, conducted on a 3–5 year basis.

Specific goals:

- first goal: Development of a policy for youth development and health, at the level of the Republic of Serbia, as well as revision of the existing and adoption of new laws and bylaws;
- second goal: At the level of the Republic of Serbia, development of a system for organised monitoring and surveillance of young people's state of health which enables decisions in the field of youth development and health to be based on reliable information;
- third goal: To develop, at the level of the Republic of Serbia and at local level, a functional partnership for youth development and health, with the promotion and intensification of active participation of young people in activity creation;
- fourth goal: To strengthen community capacities, at local level, for planning, implementation, monitoring and evaluation of prevention, treatment and rehabilitation programs, as well as in the creation of a safer and healthier family, school and work environment for young people;
- fifth goal: Local government action plans recognise the importance of gender equality.

Expected specific outcomes:

- at republic level, an adopted Strategy for youth development and health, as well as a set of laws that regulate mechanisms of implementation, regulation and protection of children's and human rights and youth health;
- at republic level, organised monitoring of the implementation of the adopted strategy and legal regulations;

- at republic level, adopted and developed information system for continuous monitoring of the youth health condition and development;
- all municipalities in the Republic of Serbia to appoint and to train staff in the application of the information system, and promptly send data to the central system;
- at the republic and local levels, developed coordinated cooperation between responsible entities and decision makers oriented to youth health;
- strengthened local government capacities directed towards satisfying youth needs in at least 75% of municipalities;
- local plans of action for youth development and health to be adopted and implemented in at least 75% of municipalities on the territory of the Republic of Serbia;
- local plans of action to be sensitive to gender equality.

Specific indicators:

Regarding the first specific goal:

- existence of Strategy for youth development and health of the Republic of Serbia;
- the number of adopted laws and bylaws;
- the percentage of municipalities where legislation is practically and functionally implemented.

Regarding the second specific goal:

- existence of information system for monitoring the state and development of youth health;
- the percentage of municipalities with persons trained for the implementation of computer programs and work on the information system;
- the percentage of municipalities that regularly submit data and fill the central database.

Regarding the third specific goal:

- the percentage of municipalities in which there is coordinated cooperation between responsible entities and decision makers oriented to youth health, i.e. in which "partnerships for health" have been developed.

Regarding the fourth specific goal:

- the percentage of municipalities with developed local government action plans for youth development and health.

Regarding the fifth specific goal:

- gender structure of persons responsible for implementing local government action plans..

Data source:

- Government Report (first indicator);
- research of youth opinions, conducted on a 3–5 year basis.

7.1.2 To develop an adequate system for transferring knowledge and skills to acquire attitudes, habits and behaviour leading to health

Expected general outcome:

- at least 75% of young people from the general population, and 50% of young people from particularly vulnerable, marginalized and socially disadvantaged groups of young people to have the necessary knowledge and skills regarding healthy lifestyles, to protect themselves against sexually transmitted infections and HIV/AIDS; abuse and neglect; unwanted pregnancy; eating disorders; mental health disorders; suicides; violent behaviour on the part of young people; and abuse of psychoactive substances.

General indicator:

- the percentage of young people who have acquired the required knowledge, skills, attitudes, and behaviour, while monitoring the gender structure of young people – a set of indicators.

Data source:

- studies conducted on a 3–5 year basis.

Specific goals:

- first goal: Development, standardisation, accreditation, implementation and monitoring of youth health promotion program at national and local levels;
- second goal: Development, standardisation, accreditation, implementation and monitoring of youth health promotion program conducted by young people ("peer approach");
- third goal: Development, standardisation, accreditation, implementation and monitoring of preventive programs targeting particularly vulnerable, socially disadvantaged and marginalised young people;
- fourth goal: Introduction of health education in school curriculums and their full implementation;
- fifth goal: Programs sensitive to gender equality.

Expected specific outcomes:

- professional preventive programs and campaigns – to be developed, accredited, and conducted continuously, monitored and evaluated in at least 75% of municipalities on the territory of the Republic of Serbia;
- peer preventive programs and campaigns – to be developed, standardised, accredited, conducted continuously, monitored and evaluated in at least 75% of municipalities on the territory of the Republic of Serbia;

- preventive programs for particularly vulnerable, marginalised and socially disadvantaged young people – to be developed, accredited, conducted continuously, monitored and evaluated in at least 75% of municipalities on the territory of the Republic of Serbia;
- health education to be introduced in school curriculums; teachers to be trained; and the subject to be taught to senior years of primary and secondary schools on the territory of the Republic of Serbia;
- programs are intended both for young men and for girls, and they recognise and respect gender equality and specific gender characteristics.

Specific indicators:

Regarding the first specific goal:

- the number of accredited programs in each area of health promotion;
- the number of accredited trainers;
- the number of trained experts;
- the number of municipalities that conduct programs.

Regarding the second specific goal:

- the number of accredited programs in each area of health promotion;
- the number of accredited trainers;
- the number of peer educators;
- the percentage of municipalities that conduct programs.

Regarding the third specific goal:

- the number of accredited programs in each area of health promotion;
- the number of accredited trainers;
- the number of trained field workers;
- the percentage of municipalities that conduct programs.

Regarding the fourth specific goal:

- existence of a unique concept of health education in school curriculums;
- the number of trained teachers;
- the percentage of primary and secondary schools that have introduced health education, presented per year.

Regarding the fifth specific goal:

- gender structure of accredited trainers;
- gender structure of peer educators;
- gender structure of field workers;
- gender structure of trained teachers.

Data source:

- the Ministry of Health; the Ministry of Labour, Employment and Social Policy; the Ministry of Finance; the Ministry of Justice; as well as healthcare, educational and social welfare institutions.

7.1.3 Improving and standardising youth healthcare quality, with a special focus on adapting services to the developmental needs of young people

Expected general outcomes:

- at national level, quality standards of youth healthcare and quality control system to be established;
- at local level, at least 75% of municipalities to have strengthened capacities of all relevant services for youth health and development, and at least 75% of municipalities to have multidisciplinary youth counselling services that meet work quality standards.

General indicators:

- existence of youth healthcare quality standards, and a system of accreditation for health and other relevant workers;
- percentage of young people using multidisciplinary youth counselling services;
- existence of work quality control system;
- coverage of health workers and assistants additionally trained for working with young people.

Data source:

- report of the Ministry of Health;
- research of youth opinions, conducted periodically on a 3–5 year basis, as well as monitoring of the state of youth health at the level of the Republic of Serbia.

Specific goals:

- first goal: Development and adoption of national programs and good practice guidelines;
- second goal: Development and adoption of work control protocols;
- third goal: Raising professional capacities and the introduction of a licensing process for health professionals and professionals from other fields related to youth health;
- fourth goal: Improvement of existing and formation of new youth-friendly services, with a definition of the system of control of their work and co-ordination;
- fifth goal: Capacity strengthening (personnel, facilities, equipment) of institutions oriented to providing assistance and treatment to young people;
- sixth goal: Reduce stigmatisation of and discrimination against young people who have fallen ill, those who need special support, as well as those who are socially disadvantaged and abused.

Expected specific outcomes:

- a national program and good practice guidelines – to be developed and distributed to all relevant institutions and individuals;
- introduction of a system of licensing of individuals in the healthcare system;
- in at least 75% of municipalities in the Republic of Serbia, there should be multidisciplinary youth counselling services with standardised work quality, contents and approach;
- developed systems and measures to be undertaken to reduce stigmatisation of and discrimination against young people who have fallen ill, those who need special support, and those who are socially disadvantaged and abused, in at least 75% of municipalities in the Republic of Serbia;
- developed systems for efficient reporting and elimination of consequences of stigmatisation of and discrimination against young people who need special support, including those who have fallen ill or who have been abused, in at least 75% of municipalities on the territory of the Republic of Serbia;
- over 75% of institutions to be directed to health promotion and improvement of capacities for the treatment of young people (personnel, facilities, equipment).

Specific indicators:

Regarding the first specific goal:

- existence of national standards and good practice guidelines;
- percentage of health institutions/individuals acquainted with national standards and good practice guidelines.

Regarding the second specific goal:

- developed and adopted work protocols.

Regarding the third specific goal:

- the percentage of health and other workers with licences.

Regarding the fourth specific goal:

- the percentage of municipalities with developed standardised youth counselling.

Regarding the fifth specific goal:

- the percentage of institutions aimed at providing assistance and treatment to young people, that have improved their capacities (personnel, facilities, equipment).

Regarding the sixth specific goal:

- the percentage of municipalities with developed stigmatisation and discrimination reduction programs;
- the percentage of municipalities with a developed system of reporting and elimination of the consequences of stigmatisation and discrimination.

Data source:

- the Ministry of Health; the Ministry of Labour, Employment and Social Policy; the Ministry of Finance; the Ministry of Justice; as well as healthcare, educational and social welfare institutions.

8 TASKS AND ACIVITIES

8.1 To develop a safe and supportive environment for youth development and health

8.1.1 At national level, the development of a strategy for youth development and health, as well as revision of the existing and adoption of new laws and bylaws

8.1.1.1 Establishment and development of national youth policy.

8.1.1.2 Revision of the existing and adoption of new laws and bylaws.

8.1.2 At national level, development of a system for organised monitoring and surveillance of the state of youth health, which enables decision-making in the field of youth development and health to be based on reliable information

8.1.2.1 Continuous monitoring of youth health needs and utilisation of healthcare.

8.1.2.2 Development of a single database on youth health.

8.1.2.3 Decision-making in the area of youth development and health based on reliable information.

8.1.2.4 Capacity development for scientific and research work.

8.1.3 To develop, at national and local levels, functional partnerships for youth development and health, with the promotion and intensification of active participation of young people in activity creation

8.1.3.1 Better coordination and cooperation between responsible entities and decision-makers oriented to youth health.

8.1.3.2 Promotion and intensification of active youth participation in the creation of health activities, at national and local levels.

8.1.4 Improving community capacities, at local level for planning, implementation, monitoring and evaluation of programs for prevention, treatment and rehabilitation of young people, as well as for creating a safer and healthier family, school and working environment for young people

8.1.4.1 Improving capacities of the local community for planning, implementation, monitoring and evaluation of programs for prevention.

8.1.4.2 Creating a safer and healthier life, school and working environment for young people.

8.1.5 Local government action plans recognise the importance of gender equality

8.1.5.1 Inclusion of both sexes as persons responsible for activities related to the implementation of local government action plans.

8.2 To develop an adequate system for knowledge and skill transfer in order to acquire the attitude, habits and behaviour that lead towards health

8.2.1 Development, standardisation, accreditation, implementation and monitoring of youth health promotion programs, at national and local levels, conducted by the professional public

8.2.1.1 Preparation and development of youth health promotion programs.

8.2.1.2 Training of persons responsible for program activities at national and local levels.

8.2.1.3 Development of operative plans for activity implementation at national and local levels, while respecting local community needs.

8.2.1.4 Organisation and implementation of activities at places of youth education.

8.2.1.5 Organisation and implementation of activities at places where young people spend free time.

8.2.1.6 Use of media, youth internet network, telephone and internet counselling.

8.2.2 Development, standardisation, accreditation, implementation and monitoring of youth health promotion programs conducted by young people (“peer approach”)

8.2.2.1 Preparation and development of peer programs for youth health promotion.

8.2.2.2 Training young people to be responsible for preventive activities (peer educators), at national and local levels.

8.2.2.3 Development of operational plans for activity implementation at republic and local levels, while respecting local community needs.

8.2.2.4 Implementation of peer education and formation of “youth-to-youth” support groups.

8.2.3 Development, standardisation, accreditation, implementation and monitoring of targeted preventive programs and campaigns for particularly vulnerable, socially disadvantaged and marginalised youth groups

8.2.3.1 Preparation and development of targeted preventive programs.

8.2.3.2 Training of persons responsible for preventive activities at national and local levels.

8.2.3.3 Development and improvement of programs for more active, equal inclusion within the social environment.

8.2.3.4 Formation and development of peer and youth groups that work as self-help/youth-to-youth groups and network spreading.

8.2.4 Introduction of health education in school curriculums and their full implementation

8.2.4.1 The introduction into regular school curriculums of health and physical education (current health education topics).

8.2.4.2 Particular training (additional training) of teachers who would be responsible for health education in schools.

8.2.5 Programs are intended both for young men and girls, and they recognise and respect gender equality and specific gender characteristics

8.2.5.1 Programs cover the issues specific to both sexes.

8.2.5.2 Inclusion of both sexes in peer education.

8.2.5.3 Inclusion of both sexes in field work.

8.2.5.4 Inclusion of teachers of both sexes in training.

8.3 Promotion and unification of youth healthcare quality with a special review of the adaptation of services for youth development needs

8.3.1 Development and adoption of national programs and good practice guidelines

8.3.1.1 Preparation and development of programs and guidelines.

8.3.2 Development and adoption of work quality protocols

8.3.2.1 Identification of the work area where work quality improvement is needed.

8.3.2.2 Supportive supervision.

8.3.2.3 Adoption of action plans for work quality promotion.

8.3.3 Raising professional capacities and the introduction of a licensing process of health professionals and professionals in other fields related to youth health

8.3.3.1 Continuous education of professionals in health and other fields related to youth health.

8.3.3.2 Introduction of a licensing process for health workers and other professionals.

8.3.4 Development of the existing and the establishment of new youth-friendly services, with a defined system for their work and coordination control

8.3.4.1 Spreading the institution network and services that will provide youth health promotion.

8.3.4.2 Formation and development of an accessible network of youth counselling services at primary healthcare level.

8.3.4.3 Development of an accessible network of urgent response teams/crisis intervention.

8.3.4.4 Development of a network of outreach units with preventive orientation at local level.

8.3.4.5 Definition of a system for work control and coordination of youth institutions and services.

8.3.5 Capacity strengthening (personnel, facilities, equipment) of institutions oriented to providing youth assistance and treatment

8.3.5.1 Integrated work of all three levels of healthcare services.

8.3.5.2 New in-patient units for young people with mental problems.

8.3.5.3 Strengthen, program and territorially definine existing units for youth mental health.

8.3.6 Reduce stigmatisation of and discrimination against young people who need special support, and the socially disadvantaged and abused

8.3.6.1 Development of programs for self-confidence development, communication and negotiating skills harmonised with the developmental potential of young people with mental disabilities, chronic diseases and special support requirements.

8.3.6.2 Adaptation of architecture for young people with special needs.

9 PLAN OF ACTION

The Plan of Action has been printed along with this strategy and forms its integral part.

10 FINAL PART

This strategy is to be published in the “Official Gazette of the Republic of Serbia”.

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GOVERNMENT

PRIME MINISTER
Vojislav Kostunica

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ANNEXES

Annex 1

PARTICIPANTS OF THE STRATEGY DEVELOPMENT PROCESS

Annex 2

MEMBERS OF THE SUBGROUPS OF THE EXPERT GROUP

Annex 3

ACTION PLAN

Annex 1

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Republic institutions, governmental and nongovernmental organisations, associations, professional and youth groups – important for the Strategy preparation and implementation

The Ministry of Health of the Republic of Serbia

The Ministry of Education and Sport of the Republic of Serbia

The Ministry of Labour, Employment and Social Policy of the Republic of Serbia

The Ministry of Science and Environmental Protection

The Ministry of Capital Investments

The Ministry of Justice

The Ministry of Finance

Expert groups and Republican experts' commissions of the Ministry of Health of the Republic of Serbia

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The Public Health Institute of Serbia "Dr Milan Jovanovic – Batut"

The Belgrade Students' Health Care Institute

The Belgrade Public Health Institute

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Y–PEER Serbia – Youth Peer Education Network

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Annex 3

ACTION PLAN

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
GOAL 1 TO DEVELOP A SAFE AND SUPPORTIVE ENVIRONMENT FOR YOUTH DEVELOPMENT AND HEALTH				
Sub-goal 1.1 At republic level, to develop strategy for youth development and health, as well as revision of existing and adoption of new laws				
1.1.1 Establishment and development of national youth policy	▪ To develop Strategy for youth health development of Republic of Serbia ▪ To adopt concrete measures (operative plan) for strategy implementation	▪ Strategy adopted ▪ Operative plan prepared and adopted	▪ Government ▪ Ministry of Health	Upon adoption
1.1.2 Revision of existing and adoption of new laws and bylaws	▪ To make review of existing laws and bylaws that regulate youth development and health ▪ According to adopted Strategy for youth health development, to make law and bylaw proposals that have to be adopted ▪ To provide (support) harmonization of legal regulations with international norms and standards ▪ To participate in monitoring of law and bylaw implementation	▪ Review of laws and bylaws performed ▪ Number of proposed new regulations/number of adopted ones	▪ Ministry of Health ▪ Ministry of Justice	12 months 12 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
Sub-goal 1.2 At republic level, to develop strategy for youth development and health, as well as revision of existing and adoption of new laws and bylaws				
1.2.1 Continuous monitoring of youth health needs and utilisation of health care	▪ To determine mechanisms for continuous and overall monitoring of youth health needs ▪ To determine clear indicators for monitoring health care use by young people ▪ To identify young people with special health risks ▪ To conduct surveys of specific conditions and problems related to mental health, reproductive health, behaviour characteristics, addiction diseases, nutrition, etc.	▪ Determined mechanism for adequate monitoring ▪ Adopted indicators ▪ Number of commenced researches ▪ Number of young people included/ number of municipalities included	▪ Ministry of Health ▪ Public Health Institute of Serbia "Dr M. Jovanovic – Batut" ▪ Mother and Child Health Care Institute of Serbia "Dr Vukan Cupic" ▪ Institute for Students' Health Care, Belgrade ▪ Healthcare institutions, social welfare institutions and educational institutions	12 months 12 months Continuously
1.2.2 Development of a single database on youth health	▪ To define special interest for monitoring youth health within development of healthcare information network ▪ To establish a single database for the territory of the Republic of Serbia for collection and monitoring of youth health data ▪ To perform necessary training for persons responsible for database maintenance at local level	▪ Established information database ▪ Number of performed training/trainees	▪ Public Health Institute of Serbia "Dr M. Jovanovic – Batut" ▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions	12 months 12 months 15 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
1.2.3 Evidence based decision making in the area of youth development and health	▪ To monitor periodically youth health behaviour through research conducted on 3–5 year basis, on representative youth sample of Republic of Serbia ▪ To start with decision-making regarding priorities of youth needs and healthcare service development, based on performed research	▪ Number of conducted research ▪ Number of decisions made based on research	▪ Ministry of Health ▪ Public Health Institute of Serbia "Dr M. Jovanovic – Batut" ▪ Healthcare institutions, social welfare institutions and educational institutions	Continuously Continuously
1.2.4 Capacity development for scientific-research work	▪ To establish the national plan and program for scientific and research work in area of youth development and health	▪ National plan established	▪ Ministry of Health ▪ Ministry of Education and Sports ▪ Ministry of Science and Environmental Protection	12 months
Sub-goal 1.3 To develop, at national and local levels, functional partnerships for youth development and health with promotion and intensification of active participation of young people in activity creation				
1.3.1 Better coordination and cooperation between those responsible for activity implementation and decision-makers oriented to youth health	▪ To strengthen relations and cooperation between healthcare and other sectors in implementing specific projects oriented to youth health ▪ To identify individuals within ministries and sectors responsible for youth health issues and establish links between them	▪ Identified individuals and potential mechanisms of inter-sectoral cooperation ▪ Number of local measures taken through inter-sectoral cooperation	▪ Ministry of Health ▪ Ministry of Education and Sport ▪ Ministry of Labour, Employment and Social Policy	Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
	▪ To develop coordinated action of state, private and non-governmental organisations (including youth organizations as well) in direct work with young people at national level ▪ To develop inter-sectoral strategies and evaluation action plans in order to reduce the risk of overlapping in planning and financing ▪ At local level – to solve priority problems of local community through partnership for health, with full participation of young people to whom the problems refer ▪ To support inter-sectoral cooperation and better relations with the community and its structures ▪ To mobilize, as partners, parents, guardians, teachers, health workers, decision makers, media, religious organisations ▪ To evaluate influence of all the suggested policies on youth health ▪ To further invest and support actions of local communities and community development programs dealing with youth health issues and to satisfy local priorities via cooperation between all partners in the community (education, healthcare, social welfare, industry, etc; non-governmental sector)		▪ Healthcare institutions, social welfare institutions and educational institutions ▪ Local government ▪ In cooperation with associations	

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
1.3.2 Promotion and intensification of active youth participation in creation of health activities at national and local levels	▪ To investigate, through participatory research, possible mechanisms for inclusion and participation of young people at local and national levels ▪ To establish youth forums on local healthcare boards: ⬩ establish student parliaments in all primary and secondary schools in the Republic of Serbia, and create boards or appoint individuals within them who would be responsible for various youth-related issues ⬩ boards or individuals should report to the parliament representative who is a member of healthcare boards within the municipality, as well as headteachers ▪ To develop inter-sectoral cooperation on all levels, and to develop partnerships between state, private, non-governmental sector; encouraging young people to actively participate as partners in creation of healthcare policy and actions intended for them ▪ To establish youth forums on local healthcare boards	▪ Number (%) of municipalities with established youth participation in health areas ▪ Number (%) of municipalities with youth forums on local healthcare boards	▪ Ministry of Health ▪ Local government ▪ In cooperation with associations	Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
Sub-goal 1.4 Capacity strengthening of the community for planning, implementation, monitoring and evaluation of programs for prevention, treatment and rehabilitation of young people at local level, as well as for creating a safer and healthier family, school and working environment for young people				
1.4.1 Local government capacity strengthening	▪ To develop and support schools as partners at local level, where a great number of young people – and through them their families/ parents and community – can be influenced effectively and efficiently, as follows: ◦ by informing schools about the possibility of cooperation with the local community, i.e. encouraging them to do so ◦ by including the private sector as investors, and finding a mode of cooperation ▪ To create, in schools and healthcare institutions, an environment safe from abuse which provides young people with understanding, care, non-discrimination and respect: ◦ by forming youth boards for preventing abuse and violence ◦ by creating a protocol for the behaviour of teachers and other school staff ◦ by appointing, within schools, a person who will protect the rights of young people	▪ Number (%) of primary and secondary schools, as well as students dormitories with special programs ▪ Number (%) of cities /municipalities included in program "Healthy cities"	▪ Local government ▪ Educational institutions ▪ In cooperation with associations ▪ Healthcare and social welfare institutions	Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
	▪ To create a possibility for overall, and particularly psychological support and assistance for young people outside healthcare and psychiatric institutions – in schools, students' dormitories and boarding schools, and also through opening counselling services in cities – outside any kind of institution (youth clubs and similar) ▪ To adopt a program to synchronize activities at community level ▪ To support "healthy cities" programs in local government, where young people would be engaged in activity planning and implementation			
1.4.2 To achieve a safer and healthier life, school and working environment for young people	▪ To support further implementation of existing programs promoting youth health ▪ To initiate development of new programs for promotion of youth health ▪ To promote education programs for teachers /employees related to creation of friendly work environment for young people ▪ To recognise and meet the needs of young people who are seen as different owing to their special needs ▪ To support and increase awareness among students and school personnel regarding issues related to young people with chronic diseases and disabilities – which, perhaps, even induced them to drop out of school – who have special needs in the school environment	▪ Number of clearly defined programs ▪ Number of newly started programs ▪ Number (%) of young people included in these programs – distribution according to programs ▪ Number (%) of schools with programs for parents ▪ Number (%) of trained teachers for early detection of disturbances /disorders	▪ Ministry of Health ▪ Healthcare and educational institutions and social welfare institutions	Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
	▪ To provide opportunities for education of parents on youth development needs ▪ To ensure that students have direct access to counselling and instruction – particularly in areas of reproductive health, mental health, and abuse of alcohol and drugs ▪ To provide training that will help teachers and other school personnel to recognize early signs of mental diseases and abuse of alcohol and drugs, as well as other health issues ▪ To develop and support the development of a network of health promoting schools and the formation of a "healthy" school network in accordance with the World Health Organisation initiative entitled Global School Health Initiative	▪ Number (%) of "healthy" schools ▪ Number (%) of schools serving optimum school meals ▪ Number (%) of schools with adequate gymnasiums ▪ Number (%) of schools meeting sanitary and hygienic standards		
Sub-goal 1.5 Plans of action of the local government recognise the importance of gender equality				
1.5.1 Appointing persons of both sexes as those responsible for implementation of local plans of action	▪ Encouraging the appointment of persons of both sexes as those responsible for implementation of local plans of action	▪ Gender structure of those responsible for implementation of local plans of action	▪ Local government	Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
GOAL 2 TO DEVELOP AN ADEQUATE SYSTEM OF TRANSFER OF KNOWLEDGE AND SKILLS IN ORDER TO ACQUIRE ATTITUDES, HABITS AND BEHAVIOUR LEADING TO HEALTH				
Sub-goal 2.1 Development, standardisation, accreditation, implementation and monitoring of youth health promotion program at national and local levels, implemented by the expert public				
2.1.1 Preparation and creation of youth health promotion program	▪ To appoint responsible entities ▪ To review existing programmes ▪ Defining standards ▪ Standardisation of existing programs ▪ To initiate and participate in making new programs for youth health promotion	▪ Responsible entities appointed ▪ Mapping of existing programs performed ▪ Established standards for all areas significant for youth development and health ▪ Number of standardised programs, geographic distribution and distribution according to areas ▪ Preparation of programs started	▪ Ministry of Health ▪ Ministry of Education and Sport ▪ Ministry of Labour, Employment and Social Policy ▪ Mother and Child Health Care Institute of Serbia "Dr Vukan Cupic" ▪ Institute for Students' Health Care ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ Local government ▪ In cooperation with associations	6 months 6 months 6 months Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
2.1.2 Training of those responsible for program activities at republic and local levels	▪ Defining training content: health workers and health associates, teachers, media representatives, local government and social welfare ▪ Training implementation ▪ Introduction of continuous education in education system	▪ Necessary training contents determined ▪ Number of municipalities included in training ▪ Number of implemented training sessions/trained persons ▪ Profile structure of experts included in training	▪ Ministry of Health ▪ Ministry of Education and Sport ▪ Mother and Child Health Care Institute of Serbia “Dr Vukan Cupic” ▪ Institute for Students’ Health Care ▪ Local government ▪ In cooperation with associations	12 months Continuously
2.1.3 Development of operative plans at national and local levels	▪ Preparation of operative plan at national level ▪ Geographic distribution of the national plan and creation of the operative plan at local level ▪ Strengthening capacities of healthcare and educational institutions	▪ National operative plan prepared ▪ Number of prepared local operative plans – distribution according to municipalities	▪ Ministry of Health ▪ Ministry of Education and Sport ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ Local government	12 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
2.1.4 Organisation and implementation of activities at places where young people learn	▪ Introduction of topics related to youth development and health in school magazines ▪ Preparation, making and distribution of promotional / health-education material for young people ▪ Organising health education forums and workshops	▪ Number of articles related to youth development and health in school magazines ▪ Number and amount of different areas important for youth development and health in education material with participatory definitions ▪ Number of distributed copies and distribution schedule of education material ▪ Number of health-education forums /workshops and their presence in different areas of the Republic of Serbia/estimate of number of young people who attended the above	▪ Healthcare institutions, social welfare institutions and educational institutions ▪ Local government	12 months Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
2.1.5 Organisation and implementation of activities at places where young people spend free time	▪ Preparation, making and distribution of promotional/health-education material for youth ▪ Promotional activities in the field ▪ To include public and popular persons in promotional activities, as well as structures where young people spend free time	▪ Number of different educational materials defined through participation/number of distributed copies ▪ Number of activities in the field/estimate of number of young people involved ▪ Number of popular persons involved	▪ Healthcare institutions ▪ Local government ▪ In cooperation with associations	6 months Continuously Continuously
2.1.6 Use of media, youth internet networks; telephone and internet counselling services	▪ Strengthening of existing telephone counselling services and opening of new ones ▪ Spreading and maintaining existing internet network ▪ Preparation of media plan ▪ Organisation and implementation of promotional activities in the audio-visual media ▪ Preparation, making and distribution of promotional/health-education material for young people	▪ Number of different educational materials defined through participation/number of distributed copies ▪ Number of internet network users/telephone counselling services ▪ Existence of media plan ▪ Number of implemented activities by means of audio-visual media ▪ Number of young people included through different types of media communication	▪ Healthcare institutions, social welfare institutions and educational institutions ▪ Local government ▪ In cooperation with the media	Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
Sub-goal 2.2 Development, standardisation, accreditation, implementation and monitoring of youth health promotion programs conducted by young people at national and local levels (peer approach)				
2.2.1 Preparation and creation of peer programs for youth health promotion	▪ To designate responsible entities ▪ To review existing programs ▪ To define standards ▪ Standardisation of existing programs ▪ To initiate and participate in creation of new preventive programs for young people	▪ Responsible entities designated ▪ Existing programs mapped ▪ Standards adopted ▪ Number of newly-developed programs	▪ Ministry of Health ▪ Ministry of Education and Sport ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with NGOs	12 months 12 months 12 months Continuously
2.2.2 Training of persons responsible for preventive activities (peer educators)	▪ To define content of peer educators' training ▪ Training implementation ▪ To establish a system of continuous training of peer educators through the school system, healthcare services and/or associations	▪ Necessary training content defined ▪ Number of performed training sessions/ trained peers	▪ Mother and Child Health Care Institute of Serbia "Dr Vukan Cupic" ▪ Institute for Students' Health Care ▪ In cooperation with peer educator networks ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	12 months Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
2.2.3 Development of operative plans at national and local levels	▪ To develop operative plan at republic level ▪ To develop operative plan at local level	▪ Republic operative plan prepared ▪ Number of prepared local operative plans – distribution according to municipalities	▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ Local government ▪ In cooperation with associations	6 months 6 months 6 months
2.2.4 Implementation of peer education and formation of supporting “youth-to-youth” groups	▪ Peer education at places where young people learn ▪ Peer education at places where young people live and spend free time ▪ Peer education by using different means of communication ▪ Formation of “youth-to-youth” groups for assistance and support, outside healthcare institutions, but with professional supervision	▪ Number of performed workshops/young people involved ▪ Number of supporting groups formed	▪ Local government ▪ In cooperation with associations	Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
Sub-goal 2.3 Development, standardisation, accreditation, implementation and monitoring of targeted preventive programs and campaigns for particularly vulnerable, socially disadvantaged and marginalised youth groups				
2.3.1 Preparation and creation of targeted preventive programs	▪ To appoint responsible entities ▪ To review existing programs ▪ To define standards ▪ To standardise existing programs ▪ To initiate and participate in making new preventive youth programs ▪ To prepare the national program of primary prevention of risk factors for the appearance of chronic mass non-infectious diseases – primarily cardio-vascular diseases – in accordance with recommendations of the World Health Organisation (hereinafter: WHO) (Global Strategy on Diet, Physical Activity and Health) ▪ To make and implement the national program and policy related to nutrition in accordance with WHO recommendations (Food and Nutrition Action for Europe) ▪ To make and implement the national program of continuous monitoring of growth, development and nourishment of young people and application of relevant programs for improving nutrition ▪ To develop models for registration and monitoring ▪ Standardisation of work protocols	▪ Responsible entities appointed ▪ Existing programs mapped ▪ Standards adopted ▪ Number of newly-developed programs ▪ Prepared model for registration and monitoring ▪ Work protocols standardised ▪ Prepared models of the said programs, as well as a single methodology	▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	12 months for preparation; continuous implementation

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
2.3.2 Training of persons responsible for preventive activities at republic and local levels	▪ To define content of training: health workers and assistants, teachers, media representatives ▪ Sensitisation of health workers and assistants ▪ Training to promptly recognize and satisfy specific needs, especially of vulnerable, socially disadvantaged and marginalised young people ▪ Training implementation ▪ Inclusion in the system of education and continuous education	▪ Defined training contents ▪ Number of trained health workers and assistants ▪ Adequate contents introduced into education system and continuous education	▪ Ministry of Health ▪ Ministry of Education and Sport ▪ Mother and Child Health Care Institute of Serbia “Dr Vukan Cupic” ▪ Institute for Students’ Health Care ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	Continuously
2.3.3 Development and strengthening of programs for more active, equal inclusion in social environment	▪ To make and develop inclusion programmes ▪ Mobilisation of youth for program development and implementation	▪ Specific programs developed ▪ Developed mechanism for mobilization of young people ▪ Number of young people mobilised for program implementation	▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	12 months Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
2.3.4 Formation and development of peer and youth groups – “youth-to-youth”, self-help groups and network spreading	▪ To increase sensitivity of young people to this type of problem ▪ Standardisation of peer self-help programs ▪ Training of volunteers ▪ Continuous peer work ▪ Forming of self-help group network ▪ Supervision ▪ Field work	▪ Number of trained volunteers ▪ Number of field activities/ workshops carried out ▪ Number of young people involved	▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	Continuously
Sub-goal 2.4 Introduction of health education in curriculums and its full implementation				
2.4.1 Introduction of health education into regular curriculums	▪ To define activities, scope and content of health education ▪ To introduce health education as a compulsory form of teaching ▪ Sensitisation of teachers to introducing health education in schools	▪ Content defined ▪ Health education introduced as part of compulsory education ▪ Number of schools and distribution where the sensitisation of teachers has been performed	▪ Ministry of Education and Sport ▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	9 months 9 months 9 months Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
2.4.2 Additional education of teachers and professors responsible for health education in schools	▪ To define the profile of teachers who would teach health education ▪ Education of teachers who would teach health education ▪ To lobby for expanding the curriculums of colleges from which teachers will be recruited for implementing health education	▪ Number of trained teachers ▪ Expanded curriculum of adequate universities	▪ Ministry of Education and Sport ▪ Ministry of Health ▪ Healthcare and educational institutions ▪ In cooperation with associations	9 months 9 months 9 months
Sub-goal 2.5 Programs are intended both for boys and for girls, and they recognise and respect the gender equality and specific characteristics of both sexes				
2.5.1 Programs cover the issues characteristic for both sexes	▪ Topics covering the problems encountered by both sexes should be included in the program contents	▪ Gender structure of accredited trainers	▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	Continuously
2.5.2 Including both sexes in peer education	▪ Encouraging both sexes to get involved in peer education	▪ Gender structure of peer educators	▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
2.5.3 Including both sexes in field work	▪ Encouraging both sexes to get involved in field work	▪ Gender structure of field workers	▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	Continuously
2.5.4 Including teachers of both sexes in the training	▪ Encouraging teachers of both sexes to get involved in the training	▪ Gender structure of trained teachers	▪ Ministry of Education and Sport ▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	Continuously

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
GOAL 3 PROMOTION AND UNIFICATION OF YOUTH HEALTH CARE QUALITY, WITH A SPECIAL REVIEW OF SERVICE ADAPTATION TO YOUTH DEVELOPMENT NEEDS				
Sub-goal 3.1 Development and adoption of national programs and good practice guidelines				
3.1.1 Preparation and creation of national programs and guidelines	▪ Adoption of national programmes ▪ Making of guidelines for different areas important for youth development and health	▪ Prepared and adopted guidelines	▪ Ministry of Health ▪ Mother and Child Health Care Institute of Serbia “Dr Vukan Cupic” ▪ Institute for Students’ Health Care ▪ Healthcare institutions, social welfare institutions and educational institutions	12 months
Sub-goal 3.2 Development and adoption of work quality protocols				
3.2.1 Identification of work area where work quality improvement is needed	▪ To make protocols for evaluation of service adjustment to youth needs ▪ To make protocols for evaluation of youth satisfaction with provided services ▪ To make protocols for evaluation of different work contents ▪ To make protocols for interviewing managers	▪ Prepared and adopted protocols	▪ Ministry of Health ▪ Mother and Child Health Care Institute of Serbia “Dr Vukan Cupic” ▪ Institute for Students’ Health Care	6 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
	▪ To make protocols for work organisation ▪ To make protocols for evaluation of education of expert team members in the area of youth development and health		▪ Healthcare institutions, social welfare institutions and educational institutions	
3.2.2 Supportive supervision	▪ Visits of the appointed team for supervision of institutions providing health care to young people ▪ Interviews with managers, service providers and users, observation and reporting	▪ Supervision team appointed ▪ Number of performed supervisions at each level ▪ Number (%) of institutions and counselling services for young people where supportive supervision is being regularly performed	▪ Ministry of Health ▪ Mother and Child Health Care Institute of Serbia “Dr Vukan Cupic” ▪ Institute for Students’ Health Care ▪ Healthcare institutions, social welfare institutions and educational institutions	Once a year
3.2.3 Adoption of action plans for work quality promotion	▪ To define an action plan, for the following period, which would correct mistakes, i.e. design appropriate changes or interventions	▪ Number of prepared plans of action for quality improvement ▪ Number of institutions with registered work quality improvement in the period between two inspections	▪ Healthcare institutions, social welfare institutions and educational institutions	Once a year

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
Sub-goal 3.3 Raising of professional capacities and introduction of licensing process of health professionals and professionals form other areas related to youth health				
3.3.1 Continuous training of health professional and professionals in other areas related to youth health	▪ Education of health workers and assistants for implementation of guidelines and work protocols ▪ Continuous education of health workers and assistants mainly at primary healthcare level, but on other health care levels as well ▪ To create a network of trained multi-disciplinary expert teams ▪ To establish work coordination between expert teams ▪ Suggestion for introduction of appropriate contents related to youth health promotion into curriculums and graduate and postgraduate education programs	▪ Number of additionally trained experts	▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions	Continuously
3.3.2 Introduction of process of health and other professional licensing	▪ To participate in the process of preparation of professional associations, educational institutions and managing structures that will issue work licences ▪ To introduce compulsory periodic education ▪ To develop the national code of ethics	▪ Periodical education introduced with implementation plan ▪ Number of founded or strengthened professional associations which will issue licences ▪ National code of ethics adopted	▪ Ministry of Health ▪ Ministry of Education and Sports ▪ Ministry of Justice	24 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
Sub-goal 3.4 Development of existing and establishment of new youth-friendly services, with a defininition of the system of work and coordination control				
3.4.1 Spreading of institution and service network that will provide youth health promotion	▪ To define the framework of operation of youth services and institutions ▪ To make youth service standards and its implementation (regarding geographic distribution, training and work standard of personnel, provided services and local community support) ▪ To form youth-friendly multi-disciplinary services in primary healthcare institutions (adjusted to age groups) ▪ To identify institutions dealing with youth health promotion and their linking ▪ To restructure organisation and scale of work of existing institutions for youth health protection and promotion, according to their needs	▪ Definition of work content of youth institutions and services ▪ Number of newly-formed youth services ▪ Number of youth services and number of municipalities with developed services	▪ Ministry of Health ▪ Mother and Child Health Care Institute of Serbia “Dr Vukan Cupic” ▪ Institute for Students’ Health Care ▪ Healthcare institutions, social welfare institutions and educational institutions	12 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
3.4.2 Formation and development of accessible network of youth counselling services at primary healthcare level	▪ To prepare an operative model of a youth counselling service which would provide primary, and partially secondary, prevention of health disorders, in accordance with options available at primary healthcare level ▪ To form multi-disciplinary youth counselling services in all primary health centres in Republic of Serbia according to youth needs and existing personnel, facility and technical possibilities ▪ Additional education of personnel for work in multi-sectoral counselling service ▪ To include young people in counselling work with support and assistance of professionals ▪ Continuous promotion of counselling services that should raise young people's awareness of the existence of such institutions and the services they offer ▪ Creation of a single web forum whose aim is the exchange of experience within the network of institutions and services dealing with youth health promotion ▪ Organising training in writing projects; preparation of a document that will establish the cooperation between healthcare institutions and NGOs	▪ Prepared operative model of youth counselling services according to established youth needs ▪ Number of restructured existing youth counselling services ▪ Number of municipalities that have youth counselling services ▪ Number of newly-formed youth counselling services ▪ Number (%) of counselling services where young people are actively involved ▪ Number of persons working in counselling services who have been additionally trained, and their professional profile	▪ Ministry of Health ▪ Mother and Child Health Care Institute of Serbia "Dr Vukan Cupic" ▪ Institute for Students' Health Care ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	24 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
3.4.3 Development of accessible network of urgent response teams/ crisis intervention	▪ Formation of teams for SOS telephone network, which will be available to young people after official working hours ▪ Linking the teams into a network ▪ Cooperation with other institutions, organisations or target groups ▪ Additional training of experts and training of new members	▪ Number of persons trained for SOS telephone service ▪ Number of teams formed ▪ Number of contacts achieved ▪ Number (%) of municipalities in Republic of Serbia from which young people call	▪ Ministry of Health ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	24 months
3.4.4 Development of network of outreach units with preventive orientation at local level	▪ To identify partners within outreach organizations and NGOs with youth health promotion as primary sphere of activity ▪ To establish network of governmental institutions and NGO with youth development and health as primary sphere of activity	▪ Number of identified strategic partners ▪ Number of established networks	▪ Local government ▪ In cooperation with associations	12 months
3.4.5 Defining a system for work control and coordination of youth institutions and services	▪ To determine basic indicators for work control of institutions and services for young people ▪ To identify (map) institutions and services for young people and to define basic principles for coordination of their work ▪ To define external supervision (every six months) by the expert team in areas covered by such a service ▪ To define monthly internal supervision of team members	▪ Established indicators ▪ Institutions and services mapped ▪ Number of performed inspections at each level ▪ Number (%) of institutions and counselling services for young people where external supervision is regular	▪ Ministry of Health ▪ Mother and Child Health Care Institute of Serbia “Dr Vukan Cupic” ▪ Institute for Students’ Health Care ▪ Healthcare institutions, social welfare institutions and educational institutions	12 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
	▪ To define regular, periodical meetings of team members of a certain health service with self-evaluation of team members ▪ To define permanent evaluation by users (young people)	▪ Number (%) of institutions and counselling services for young people where internal supervision and self-evaluation are regular ▪ Number (%) of institutions and counselling services for young people where supervision by users is regular		
Sub-goal 3.5 Capacity strengthening (personnel, facilities, equipment) of institutions oriented to youth assistance and treatment				
3.5.1 Integrated work of services at all three levels	▪ According to levels, clearly define and limit frame, scope and content of work of services intended for young people ▪ To ensure necessary linkage and effectiveness, according to healthcare levels, through a precise protocol ▪ To strengthen existing youth counselling services and spread integrated activities by introducing new contents (HIV infection prevention, PAS abuse prevention, abuse and neglect prevention, prevention of mental and eating disorders, etc) ▪ Connecting youth services at secondary level, as well as carrying out an integrated treatment and rehabilitation approach (tertiary level)	▪ Defined protocols at all levels	▪ Ministry of Health ▪ Public Health Institute of Serbia "Dr M.Jovanovic – Batut" ▪ Republic Health Insurance Institute ▪ Healthcare institutions, social welfare institutions and educational institutions	12 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
3.5.2 New in-patient units for young people with mental problems	▪ To estimate requirements on the entire territory of the Republic of Serbia for treatment of young people with mental problems ▪ To start by opening new in-patient units for treatment of young people with mental problems within existing psychiatric departments in medical centres ▪ To organise creative daily activities adapted to young people (sports, cultural activities, instructive programmes) ▪ To include volunteers – peer educators in the work of in-patient units; humanisation of spaces/rooms (bright colours, large day rooms, parks)	▪ Necessity analysis performed ▪ Number (%) of medical centres/general hospitals with open departments for treatment of young people with mental problems	▪ Ministry of Health ▪ Public Health Institute of Serbia "Dr M.Jovanovic – Batut" ▪ Republic Health Insurance Institute	24 months
3.5.3 Strengthening and defining existing units for youth mental health, according to program and territory	▪ To revise existing network of dispensary units for youth mental problem and to separate them from children's departments, as well as from children and young people with neurological disorders ▪ Depending on local needs, to open specialist and consultative outpatient units for youth mental problems (behaviour disorders, PAS abuse) at secondary healthcare level ▪ Permanent education of staff and supervision	▪ Number (%) of in-patient psychiatric units, separated for children ▪ Number of psychiatric in-patient units, separated from neurology	▪ Ministry of Health ▪ Public Health Institute of Serbia "Dr M.Jovanovic – Batut" ▪ Republic Health Insurance Institute	12 months

ACTIVITIES	STEPS	PROCESS INDICATORS	MAIN RESPONSIBLE ENTITIES AND PARTNERS	TIME FRAME
Sub-goal 3.6 Reduce stigmatization of and discrimination against young people who have fallen ill, those who need special support, and those who are socially disadvantaged and abused				
3.6.1 Development of programs for self-confidence development, communication and negotiating skills, harmonized with developmental potential of young people with mental disabilities, chronic diseases and special support requirements	▪ To appoint entities responsible for standardisation ▪ Review of existing programmes ▪ To define standards ▪ Standardisation of existing programs ▪ To initiate and participate in the creation of new preventive youth programs ▪ Development of model for registration and monitoring ▪ Work protocol standardisation ▪ Forming and strengthening programs related to becoming financially independent ▪ Broad public education ▪ To educate the media – journalists ▪ To stimulate the development of culturally appropriate and available programs, which reflect the diversity of the youth community	▪ Appointed entities responsible for activities ▪ Existing programs mapped ▪ Adopted standards ▪ Number of newly developed programs ▪ Developed model for monitoring ▪ Work protocol standardised ▪ Number of public campaigns ▪ Number of trained journalists ▪ Number of newly-developed, culturally appropriate programs	▪ Ministry of Health ▪ Ministry of Labour, Employment and Social Affairs ▪ Healthcare institutions, social welfare institutions and educational institutions ▪ In cooperation with associations	Continuously
3.6.2 Adapting architecture to young people with special needs	▪ To define legal obligation for equality in accessibility of all facilities and means ▪ To implement the legally defined obligation	▪ Regulations adopted and implemented	▪ Ministry of Capital Investments	12 months

Vocabulary

accessibility – the possibility for a patient to receive the needed health care in an appropriate scale, at reasonable prices, in a certain place and time period. It can be measured by the percentage of a given population expected to use a certain institution or service, taking into consideration the existence of corresponding physical, economical and socially cultural obstacles

accreditation – process under which an authorized agency or organization evaluates and recognizes programs or institutions that satisfy previously defined standards

action plan – plan that sets up aims, activities and tasks within a certain timeframe, defines responsible persons and needed resources

artificial abortion – deliberate miscarriage of birth

availability – the level where appropriate health service is accessible (available) to satisfy users' needs, as well as the range of health services provided in adequate scale and place, as part of a health care plan

budget – financial plan of program or activity implementation during a certain time period

certification – a process where an individual, institution or education program is evaluated and recognised, that fulfils certain, already determined standards

continuous education – formal education that a health worker receives after studies and postgraduate studies. It includes all forms of education relevant to the type of patient health care and institutional activities, in relation tothe service quality provided and knowledge relevant to the individual responsibility area

database – collection of stored data, organized accordingly into fields, notes, files, followed by a description and scheme.

de-population – trend of transfer from positive to negative population growth on a certain territory in a certain time period

evaluation – critical estimation, on the most objective basis; the level where overall service or some of its components fulfil established objectives

good practice guideline – systematically formulated instructions that provide the decision makers with the possibility of providing health care to patients within adequate clinical circumstances

growth index – represents the ratio between population over the age of 60 and the youth group up to the age of 19

health care – health promotion, prevention of illness on all levels, early diagnosis and disease treatment and rehabilitation of patients.

health care quality – the extent to which the health service provided satisfies professionally established standards and users' value judgements. It can be described on three levels: resource quality; the quality of the process of providing services; and the resulting quality of the health institution's service

health care quality control – refers to current measures of key processes in health care and the decrease of unwanted and inappropriate differences in practice performance.

indicator – variable that helps to measure change directly or indirectly; a measure of volume where objectives are achieved

intervention – process (or activities as a part of process) that improves the health status of a patient. Health interventions may be: preventive (primary), diagnostics, therapeutic (secondary) or rehabilitation (tertiary).

monitoring, follow-up, surveillance – regular monitoring of changes in certain conditions, situations or changes in order to provide its implementation according to the anticipated plan

participation – a process of direct participation of interested parties or individuals in activities that refer to management and decision-making

planning – adoption of a decision in the light of its effects in the future, a process of defining changes needed to achieve certain improvements and determining how these changes should be carried out in practice

population – all inhabitants of a country or area observed together, the number of residents of a certain country or area

population growth rate – the ratio of live-born and deceased on one territory in a certain timeframe per 1000 inhabitants

prevalence – the ratio of the total number of persons that suffer from a certain disease or the condition and total population on that territory in a defined time period

protocol – a plan or group of steps that should be followed during implementation of research and examination, or while providing health care for a defined state or disease

quality promotion – collection of all activities that provide desired quality changes

quality standard – a statement that defines expected execution, structure or processes that have to be present in a health organisation in order to promote health care quality

resources – all resources (material, financial, personnel, energy) at one's disposal for carrying out actions necessary for the achievement of necessary objectives)

risk – the probability of the creation of an unwanted event, i.e. an effect harmful to health

sexually transmitted infections – virus, bacteria, fungus and parasite infections that can be transmitted by sexual contact

specific fertility rate – the number of women who gave birth per 1000 females of a certain age

standard – a statement regarding expectations related to the degree or level of requests, decisions or achievements in execution quality

strategy – a wide range of activities conducted to achieve set short-term and long-term objectives. It includes identification of a place for intervention; determines ways of including other sectors; determines the range of political, social, economical, technical and managerial factors for the achievement of goals; it determines limitations and ways of overcoming them

training – organised and program oriented education

validity – an expression of degree where the measurement result reflects the measured quantity

Abbreviations

AIDS	AIDS, Immunodeficiency Syndrome, terminal stage of HIV infection
CHC	Clinical-Hospital Centre
EMPRONA	Enthusiasm of Youth against Narcomany, NGO
HIV	Human Immune deficiency Virus (reduced immunity), AIDS inciter
HPVPI	HIV Prevention among Vulnerable Population Initiative
IAN	International Aid Network, NGO
IDP	Internally displaced person
IPH	Institute for Public Health
JAZAS	Yugoslav Association against HIV/AIDS, NGO
MoI	Ministry of Interior
NGO	Non-governmental organization
PAS	Psychoactive substances
SPY	Safe Pulse of Youth, NGO
STI	Sexually transmitted infections
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
Y–PEER	Youth Peer Education Network
YuMSIC	Yugoslav Medical Students' International Committee

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