

VISUALISING THE PROBLEMS AND GENERATING SOLUTIONS FOR

ADOLESCENT HEALTH

IN THE AFRICAN REGION

BRAZZAVILLE | CONGO – 7th to 8th July 2015



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Acknowledgements

The regional meeting to take stock of the progress made in **Adolescent Sexual and Reproductive Health and Rights** (ASRHR), in the 20 years since the **International Conference on Population and Development** (ICPD) was organized jointly by the **Department of Reproductive Health and Research** (HQ) and the Family and Reproductive Health Cluster (AFRO). Financial support was made available by the **Department of Reproductive Health and Research** (HQ).

The meeting was planned and led by **Dr Symplice Mbola Mbassi** (Adolescent health focal person AFRO), **Dr Chandra-Mouli, Venkatraman** (Scientist, HQ/FWC/RHR/AGH) and **Dr Baltag Valentina** (Scientist, HQ/FWC/MCA/PPP).

The hard work of country representatives and experts with various backgrounds who attended the two-day meeting resulted in: (i) a shared understanding of the progress made in ASRHR in the twenty years since ICPD; (ii) a consensus on the integration of ASRHR into **National Strategic** planning and planned evaluation of RMNCAH interventions and programmes; and (iii) a set of short and medium-term actions for implementation at country level.

The following organizations made extraordinary technical contributions during the meeting: **Partnership for Maternal, Newborn & Child Health** (PMNCH), **United Nations Population Fund** (UNFPA), **United Nations Children's Fund** (UNICEF), **United Nations Entity for Gender Equality and the Empowerment of Women** (UN Women), **United Nations Educational, Scientific and Cultural Organization** (UNESCO) and **World Bank** (WB).

This report is a result of the collective efforts of many individuals. However, the drafting team includes **Dr Symplice Mbola Mbassi** (Adolescent health focal person, AFRO) and **Dr Chandra-Mouli, Venkatraman** (Scientist, HQ/FWC/RHR/AGH).

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ADOLESCENT HEALTH IN THE AFRICAN REGION

*– Visualising the problems and
generating solutions*



REPORT ON THE REGIONAL MEETING

to take stock of the progress made in adolescent Sexual and Reproductive Health and Rights, in the 20 years since the International Conference on Population and Development, and on the Opportunities and Challenges in moving the agenda forward.

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FOREWORD *Regional Director's Opening Address*

Dr Phanuel Habimana, Director: Family and Reproductive Health Cluster delivered this opening address on behalf of the Regional Director.

Demographic changes in the past decades have led to the largest generation of young people, aged 10-24 years, in the world today. This group is comprised of adolescents, aged 10-19 years, and youth aged between 15-24 years. Young people account for 28% of the global population. While this proportion will decline in most regions in the coming years, it will remain above 30% until 2035 in Africa.

Approximately 196.5 million adolescents live in the African Region, representing 31% of the population. Morbidity and mortality rates amongst the adolescent population in Africa are high compared to other regions of the world. Pregnancy-related causes, HIV/AIDS, road traffic injuries, violence, and suicide rank among the main causes of adolescent deaths in the region.

A number of other important issues affect the health of adolescents in Africa. Child marriage is one such issue. Child marriage is associated with a high adolescent pregnancy rate, estimated at 117 per 1000 girls in the region. Married girls are vulnerable to sexual and reproductive ill health, with potentially life-threatening consequences. They are also at risk of contracting human papilloma virus (HPV) leading to cervical cancer in later life, mental health problems and violence.

Other areas of concern pertain to behavioural issues such as the increasing

use of tobacco and excessive alcohol intake among adolescents in several countries. Furthermore, the increasing prevalence of illicit substance abuse, physical inactivity and unhealthy food consumption represent major regional public health issues that need to be tackled.

In 2001 the WHO Regional Committee for Africa approved the adolescent health strategy for the Region (WHO 2001) and has since supported countries to develop adolescent and youth policies and strategies, national standards for quality health care services as well as accompanying implementation plans. This technical support has resulted in improvements in adolescent and youth health service provision and progress in advancing the adolescent sexual, reproductive health and rights (ASRHR) agenda in various countries. Examples of achievements include:

- Dissemination of adolescent health care quality standards;
- Provision of adolescent and youth friendly health services;
- Scale up of adolescent and youth friendly health services;
- Implementation of adolescent health programmes at schools;
- Advocacy against early marriage and female genital mutilation (FGM); and
- Vaccination against HPV.

However, despite significant efforts and notable advancements in some areas, many African countries still face challenges in addressing adolescent sexual reproductive health and rights.

It is within this context that WHO has convened this two-day meeting in order to take stock of the progress made in ASRHR, in the 20 years since the International Conference on Population and Development (ICPD). The meeting is an ideal setting for sharing your experience and best practices. In addition you will discuss the five complementary and interrelated intervention areas to promote ASRHR.

By the end of your work at this meeting, we expect to have a clear and common understanding of challenges and opportunities pertaining to ASRHR and how to move forward with concrete actions. By sharing your extensive experience and various areas of expertise, I am firmly convinced that the benefits of this meeting will assist countries to improve ASRHR.

I would like to take this opportunity to thank all of you for your availability and your commitment to pay more attention to an age group that is often voiceless and invisible. I wish you a pleasant stay in the Regional Office, and a successful meeting with meaningful outcomes.





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LIST OF ABBREVIATIONS

ADH	Adolescent Health	MH	Mental Health
AF	Adolescent Friendly	m-Health	Mobile Health
AFHS	Adolescent Friendly Health Services	mhGAP	Mental Health Gap Action Programme
AH	Adolescent Health	MHM	Menstrual Hygiene Management
AIDS	Acquired Immune Deficiency Syndrome	MISP	Minimum Initial Service Package
ANC	Antenatal Care	MMC	Medical Male Circumcision
ARH	Adolescent Reproductive Health	MOE	Ministry of Education
ART	Antiretroviral Therapy	MOH	Ministry of Health
ASRHR	Adolescent Sexual and Reproductive Health and Rights	MP	Member of Parliament
AU	African Union	MTEF	Medium Term Expenditure Framework
BAC	Blood Alcohol Concentration	MVI	Mental Health, Violence and Injury
BOD	Burden of Disease	NCD	Non-Communicable Diseases
CAC	Community Action Cycle	NGO	Non-Governmental Organisation
CAG	Community Action Group	OA	Older Adolescents
CCHP	Comprehensive Council Health Plan	PEP	Post Exposure Prophylaxis
CHE	Comprehensive Health Education	PHC	Primary Health Care
CRC	Convention on the Rights of the Child	PoA	Programme of Action
CSE	Comprehensive Sexuality Education	PreP	Pre-exposure Prophylaxis
DALY	Disability Adjusted Life Years	PTA	Parent-Teacher Association
DFATD	Department of Foreign Affairs, Trade and Development (Canada)	RAF	Regional Accountability Framework
DHS	Demographic and Health Survey	REC	Regional Economic Commissions
DRC	Democratic Republic of Congo	RHMT	Regional Health Management Team
EFA	Education For All	RMNCH	Reproductive, Maternal, Newborn and Child Health
e-Health	Electronic Health	SACMEQ	Southern and Eastern Africa Consortium for Monitoring Educational Quality
EMIS	Education Management Information System	SBSE	School Based Sexuality Education
ESA	Eastern and Southern African	SCF	Save the Children Fund
EWEC	Every Woman Every Child	SDGs	Sustainable Development Goals
FGM	Female Genital Mutilation	SDP	Service Delivery Point
FGM/C	Female Genital Mutilation or Cutting	SE	Sexuality Education
FP	Family Planning	SERAT	Sexuality Education Review and Assessment Tool
GBV	Gender Based Violence	SMC	School Management Committee
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria	SRGBV	School Related Gender Based Violence
GFF	Global Financing Facility	SRH	Sexual and Reproductive Health
HCP	Health Care Provider	SRHR	Sexual and Reproductive Health and Rights
HIV	Human Immunodeficiency Virus	STI	Sexually Transmitted Infection
HLG	High Level Group	SV	Sexual Violence
HMIS	Health Management Information System	TC	Town Council
HPV	Human Papilloma Virus	TCG	Technical Coordinating Group
HQ	Head Quarters	TOT	Training of Trainers
HRH	Human Resources for Health	UN	United Nations
HSS	Health Systems Strengthening	UNESCO	United Nations Educational, Scientific and Cultural Organisation
IARC	International Agency for Cancer Research	UNFPA	United Nations Population Fund
ICPD	International Conference on Population and Development	UNODC	United Nations Office on Drugs and Crime
IDP	Internally Displaced Person	USA	United States of America
IMAGE	Intervention with Microfinance for AIDS and Gender Equity	USAID	United States Agency for International Development
IPPF	International Planned Parenthood Federation	VAW	Violence Against Women
IPV	Intimate Partner Violence	VHT	Village Health Team
IRH	Institute for Reproductive Health	VYA	Very Young Adolescents
IST	Inter-country Support Teams	WASH	Water Sanitation and Hygiene
LMIC	Low and Middle Income Countries	WCO	World Health Organisation Country Office
LRTI	Lower Respiratory Tract Infections	WHO	World Health Organisation
LSE	Life Skills Education	YFS	Youth and Family Services
MDG	Millennium Development Goals	YP	Young People or Young Person
M&E	Monitoring and Evaluation		



INTRODUCTION

In 1994 the International Conference on Population and Development (ICPD) held in Cairo, Egypt, articulated the clear relationships between population, development and individual wellbeing. At the Conference, 179 countries adopted a comprehensive 20-year Programme of Action (PoA) for people-centred development progress - an ambitious agenda to deliver inclusive, equitable and sustainable global development. The PoA recognized that reproductive health and rights, women's empowerment and gender equality are of fundamental importance to population and development programmes and subsequently provided a cornerstone for the Millennium Development Goals (MDGs).

The ICPD also set out a bold, clear, and comprehensive definition of reproductive health (RH) and called for nations to meet the educational and service needs of adolescents to enable them to deal with their sexuality in a positive and responsible way.

In the run up to the 20th anniversary of the ICPD, the World Health Organisation (WHO), in collaboration with the United Nations Population Fund (UNFPA) and the International Women's Health Coalition, organized an Expert Group Meeting to review research evidence and programmatic experience in adolescent sexual and reproductive health and rights (ASRHR) and to discuss implications for implementing the ICPD PoA beyond 2014. The meeting took place in February 2013 in New York with support from the Packard Foundation and the Swiss Development Cooperation Agency. Participants included representatives of national governments,

national and international NGOs, representatives of selected United Nations (UN) agencies, and researchers working in the area of ASRHR.

Prior to the meeting, WHO commissioned a series of working papers to inform the discussions. The themes covered the following five complementary and interrelated intervention areas to promote ASRHR:

- 1 Creating an enabling environment for ASRHR: What do we know about what works?
- 2 Providing Comprehensive Sexuality Education (CSE): emerging trends in evidence and practice
- 3 Providing adolescent SRH services and increasing adolescent demand and community support for their provision: What works?
- 4 Addressing intimate partner and sexual violence among adolescents: emerging evidence of effectiveness; and
- 5 Ensuring youth's right to participation and the promotion of youth leadership in the development of SRH policies and programmes.

Each paper presented an overview of the evidence on promising and effective interventions, implementation experience, and implications for policies, programmes and research. The working papers were revised based on the discussions at the Expert Group Meeting and the full set of papers – including an overview – was published in January 2015 as a Supplement of the Journal of Adolescent Health. The Norwegian Agency for Development Cooperation sponsored the publication of the Supplement. A number of North American and Western European cities

organized highly successful launch events to draw attention to the messages contained in the Special Supplement.

The articles identify key challenges that need to be confronted and critical interventions for addressing ASRHR. The key recommendations are to link the provision of sexuality education (SE) and sexual and reproductive health (SRH) services; build awareness, acceptance, and support for youth-friendly SRH education and services; address gender inequality in terms of beliefs, attitudes, and norms; and target the early adolescent period (10-14 years). However, there are many knowledge gaps that require further research on how to design effective adolescent SRH intervention packages and how best to deliver them.

It is against this backdrop that WHO Headquarters (HQ), in collaboration with Regional Offices, convened a range of regional meetings bringing together representatives of United Nations (UN) agencies, international NGOs, bilateral agencies as well as foundations and organizations operating at the country and regional level to discuss ASRHR.

The two-day African Regional Workshop was held on the 7th and 8th July 2015 and brought together ASRH experts representing various institutions such as: Ministries of Health; Ministries of Education; UN Agencies; International organizations and WHO staff from HQ, AFRO, Inter-country Support Teams (IST) and World Health Organisation Country Office (WCO). The meeting sought to achieve the following three objectives and related outputs:



Table 1 Workshop objectives and expected outputs

OBJECTIVE	EXPECTED OUTPUTS
1 To build a shared understanding of the progress made in ASRHR in the 20 years since the ICPD, and on gaps, bottlenecks, opportunities and challenges to be considered in moving the agenda forward.	<ul style="list-style-type: none"> The key messages distilled from the collection of articles will have been communicated to the participants; specifically, the need to address ASRHR more effectively, and especially the need to invest in both action and research in this area.
2 To demonstrate how these five critical, complementary and interrelated ASRHR intervention areas can be integrated into various policy development activities including national strategic planning exercises and on-going or planned evaluations of the national reproductive, maternal, new-born and child health (RMNCH) policies and processes.	<ul style="list-style-type: none"> A shared understanding will have been developed on the progress made, and on the opportunities gaps, bottlenecks, challenges in moving ahead.
3 To contribute to better coordinated programmes and evaluations that address ASRHR.	<ul style="list-style-type: none"> A consensus will have been reached on the integration of ASRHR into national strategic planning and planned evaluation of RMNCH interventions and programmes. The conclusions and recommendations of each meeting will be prepared for publication in appropriate peer-reviewed journals.

Workshop presentations and discussions were conducted in plenary and small group sessions. The final plenary presentation and discussions on the conclusions of the meeting will be published in an appropriate journal.

The workshop discussions were divided into four themed sessions:

- Overview of progress in ASRHR in the 20 years since the ICPD and 15 years of the Millennium Declaration from a global and regional perspective.
- Lessons learned from ASRHR implementation in the 20 years since

the ICPD. Discussions were based on the five interrelated themes covered in the Journal of Adolescent Health articles:

Comprehensive sexuality education (CSE); Providing adolescent friendly health services (AFHS) and increasing adolescent demand and community support for their provision; Adolescent and youth participation and leadership and Addressing intimate partner and sexual violence among adolescents; and Creating an enabling environment for ASRHR.

- Best use of global initiatives to move the country level agenda forward.

- Bringing the threads together – identifying priorities for action and research and development of a Consensus Statement.

The participants engaged in extensive discussions and debates during each workshop session and a rapporteur captured key emerging issues as well as recommendations. This report summarises key issues from the workshop presentations and discussions as well as the recommendations and conclusions from the final plenary session.



SESSION 1: Progress In ASRH In The 20 Years Since ICPD And The 15 Years Of The Millennium Declaration

1.1 The global picture Where are we in ASRHR in the 20 years since the ICPD?

This presentation by **Dr Chandra-Mouli Venkatraman, Scientist, WHO/HQ** provides an overview of the progress made in ASRHR in the past 20 years and highlights the challenges that remain to be tackled.

According to the WHO definition, the term “adolescent” is used to denote individuals between 10 and 19 years of age. Adolescence is a time of opportunity. It is also a time of risk because health problems that occur during this period might have severe immediate consequences and behaviours that begin during adolescence could also have serious adverse effects on health in the future. This is of huge significance considering that there are 1.2 billion adolescents in the world today.

The ICPD 1994, held in Cairo, laid out a clear and comprehensive definition of reproductive health and called for nations to meet the educational and service needs of adolescents to enable them to deal with their sexuality in a positive and responsible way. The ICPD was a landmark event in SRH because it created a remarkable consensus among 179 governments that individual human rights and dignity, including the equal rights of women and girls and universal access to sexual and reproductive health and rights, are a necessary precondition for sustainable development...”

In the past 20 years, the world in which adolescents are growing up has changed dramatically in many ways. Remarkable progress has been made in areas such as the significant reduction of extreme poverty; the tremendous increase in primary school enrolment; the rapid increase in the use of the new information technologies such as the internet and mobile phones; steady urbanisation, improved sanitation coverage; improvements in some aspects of gender equity in Africa; and a sharp drop in under-

five mortality as indicated in the table 2.

Table 2 Under five mortality rates, 1990 and 2012

UNDER-5 MORTALITY RATE PER 1000 LIVE BIRTHS	1990	2012
Global	90	48

Sub-Saharan Africa

Source: *United Nations. Millennium Development Goals Report. 2014*

However, despite this progress, in some ways the world has not changed since the ICPD. The year 2013 was marked by a continuation of multiple refugee crises and conflicts during the past two decades have forced an average of 32,000 people to abandon their homes daily in order to seek protection elsewhere.

Despite the fact that mortality is relatively low during the adolescent years, it is estimated that in 2012 1.3 million 10-19 year olds died, mostly from preventable or treatable causes. Empirical data and estimates clearly show that adolescent ill health and death constitute a large portion of the global burden of disease (BOD) and mortality and therefore this group needs special attention. Between 1990 and 2012, declines in mortality rates have been lower in 10-14 year olds and 15-19 year olds when compared to other age groups.

Since the ICPD there has been patchy progress in the area of adolescent sexual and reproductive health. Twenty years on, inequalities in ASRH services and outcomes still persist between and within regions and countries. The health of adolescents, and particularly their SRH, is an area of concern for a number of reasons which are summarised below:

Despite gains in selected countries, little progress has been made in preventing child marriage in developing countries – Child marriage, defined as marriage before the age of 18, is an important and often neglected factor that has an adverse influence on the lives and health of adolescent girls. According to UNFPA, there are 39,000 child marriages every day,

which means that between 2011 and 2020 140 million girls will marry. Of these, 50 million will be under the age of 15 years. There are numerous consequences for girls who marry so young, such as being unable to finish their education and being at increased risk for adolescent pregnancy and childbirth. Estimates indicate that approximately 70 to 80 percent of births among adolescents occur in married adolescents (WHO 2008).

Complications during pregnancy and childbirth are the second cause of death for 15-19 year-old girls globally – the number of births to girls aged 15-19 years declined globally from 64 per 1000 girls in 1990 to 54 per 1000 girls in 2011. However every day, 20,000 girls below the age of 18 give birth in developing countries. Approximately 19% of young women in developing countries become pregnant before reaching the age of 18 years. Girls under 15 years account for 2 million of the 7.3 million births (27%) that occur to adolescent girls under 18 years of age every year in developing countries. The risk of maternal death in adolescents is higher than in adult women.

Health issues related to pregnancy and childbirth are the second leading cause of death for adolescent females in developing countries – early pregnancies are linked with high maternal morbidity and mortality. Approximately 70,000 adolescents in developing countries die annually of causes related to pregnancy and childbirth (UNFPA 2013).

98% of unsafe abortions take place in developing countries, where abortion is often illegal – It is estimated that each year 3.2 million unsafe abortions are conducted on girls in the 15 to 19 year age group in developing countries. Unsafe abortions account for almost half of all abortions



(Sedge 2012).

WHO estimates 30% of adolescent girls, aged 15-19 years, globally experience intimate partner violence – Violence against women and girls increases the risk of adverse SRH outcomes including unwanted pregnancies, acquisition of sexually transmitted infection (STIs) and HIV, as well as other health issues affecting adolescents such as excessive alcohol consumption, substance abuse and mental health disorders. Globally, one in three women will experience physical and/or sexual violence by an intimate partner or sexual violence by someone other than their partner (WHO 2013).

Recent estimates show about 125 million women and girls living in the African Region, Yemen and Iran have been subjected to female genital mutilation (FGM)

– The high proportion of adolescents and women aged 15-49 years that support the continued practice of FGM is a concern because medical complications related to female genital mutilation occur throughout the woman's lifespan and commonly include chronic pelvic and urinary infections, severe menstrual pain, and obstetric complications affecting both mother and baby (Upvall 2009).

Increasing numbers of adolescent HIV-related deaths – Between 2005 and 2012, the global number of HIV-related deaths fell by 30% while in the same period HIV-related deaths among adolescents increased by 50% (UNAIDS 2013). In 2012, an estimated 2.1 million adolescents were living with HIV. Approximately two thirds of all new infections were in girls, and mainly in Sub-Saharan Africa (UNICEF 2013). A 2013 UNICEF study conducted in Sub-Saharan Africa indicates that only 10% of young men and 15% of young women aged 15 to 24 years were aware of their HIV status.

Most adolescents and youth do not yet have access to CSE - despite repeated intergovernmental agreements to provide it, support from the UN system and

considerable project level experience in a wide range of countries and research showing its effectiveness (United Nations 2014). The expanding window between the onset of puberty and the age of first marriage may leave a growing number of young persons without access to much needed SRH services.

On the other hand, in the face of all these challenges, new global strategies such as The Global Strategy for Women's, Children's and Adolescent Health, the new Regional Strategy for Adolescent Health and initiatives like The Global Financing Facility (GFF) in support of Every Woman and Every Child, present new opportunities to drive the ASRHR agenda.

1.2 An overview of progress in ASRHR in the African Region

Dr Symplice Mbola Mbassi, Adolescent and Youth Technical Officer, WHO AFRO presented this overview of the challenges, progress and opportunities for ASRHR in the African region.

About 196.5 million adolescents live in the African region, representing 31% of the population. Africa is the only region in the world in which the number of adolescents continues to grow substantially. This is of concern because according to research evidence, the death rate per 100,000 adolescents, both males and females, is higher in the African region than in any other region in the world (Patton 2009). Approximately 2.6 million (WHO 2011) young people globally die each year from preventable and treatable causes. In addition, approximately two-thirds of early deaths and a third of the total disease burden in adults are related to conditions and behaviours that began during adolescence.

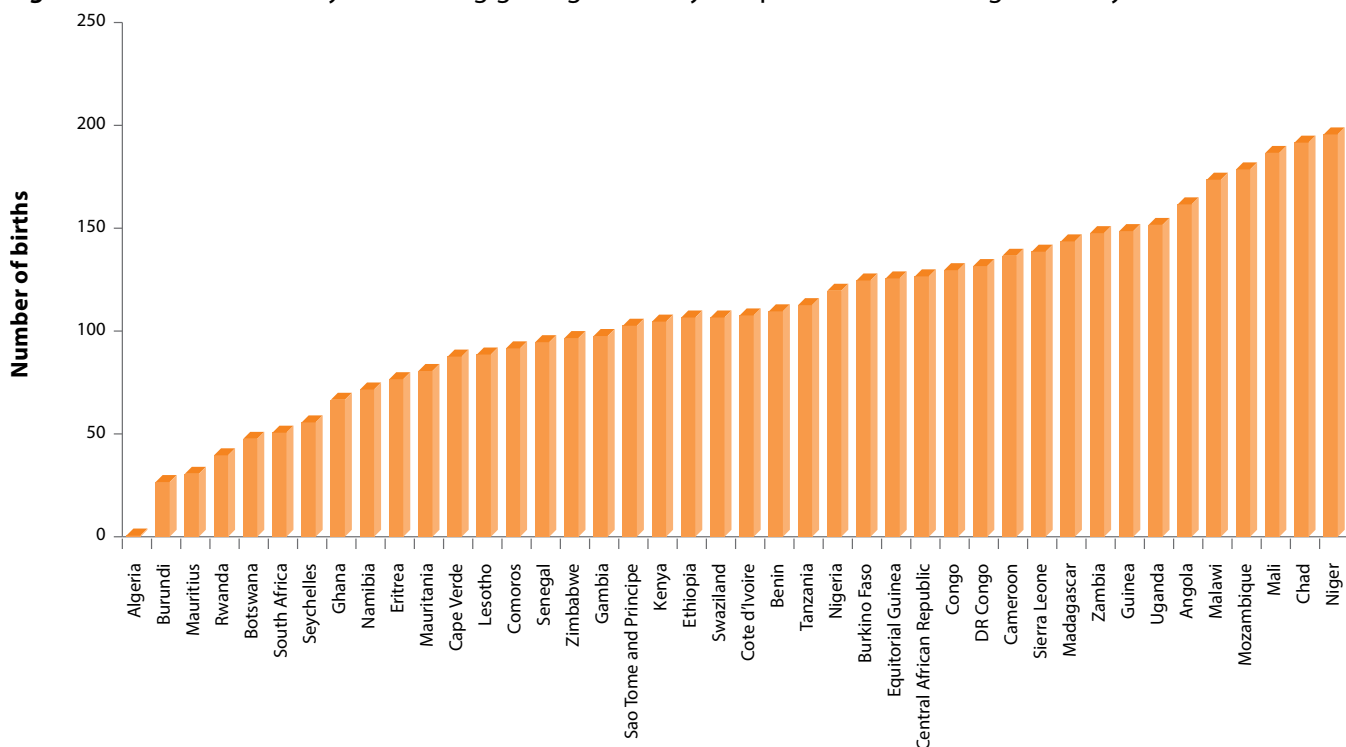
Despite increases in primary school enrollment and steady urbanization in the African region, most adolescents and youth do not yet have access to comprehensive sexuality education or to quality health services. Adolescent health and

development continues to be hampered by several challenges, such as:

Child marriage – Nine out of the 10 countries with the highest rate of child marriage are in Africa. The prevalence of child marriage in Africa varies considerably across countries, ranging from 2% in Algeria to 75% in Niger. In Chad and Niger, which have the highest prevalence, more than one in three girls is married before her 15th birthday while in Ethiopia, one in six girls is married by age 15 years. Adolescent surveys that include questions on unions and not just marriages, indicate that in 5 countries, 10% or more of the boys between 10 and 19 years of age are married or in union. However, 10% or more girls are married in 33 of the countries in the region (UNICEF 2011). Unions recognized as marriages either in statutory or customary law raise the same human rights concerns as marriage. Additional concerns due to the informality of the relationship – for example, inheritance, citizenship and social recognition – might make girls in informal unions vulnerable in different ways than those who are in formally recognized marriages (UNICEF 2005).

Adolescent pregnancy is the leading cause of death among adolescent girls in the African region – The birth rate among adolescent girls in the African region is the highest in the world. It is on average, 115 per 1000 girls aged 15-19 years, a rate that is more than double the global average of 49 per 1000. More than half of the countries in the region (n=30) have adolescent birth rates above 100 births per 1000 adolescent girls. Among the developing regions, Sub-Saharan Africa, and particularly West and Central Africa have the largest percentage (28%) of women between the ages of 20 and 24 years who reported a birth before the age 18 years. These sub-regions account for the highest percentage (6%) of reported births before the age of 15 years. In the African Region, births to adolescents under the age of

Figure 1 Adolescent fertility rate among girls aged 15-19 years per 1000 females aged 15-19 years



Source: WHO Global Health Observatory 2012

15 years are projected to double in the next 17 years. Adolescent pregnancy is the leading cause of death among adolescent girls in the African region (Gore 2011).

Africa has the highest number of unsafe abortions – The African Region has the highest rate of unsafe abortions (26 per 1000 girls aged 15-19 years) worldwide. The Region accounts for 44% of all unsafe abortion among adolescents aged 15 - 19 years in developing countries, excluding East Asia. Each year, 36 000 women and girls die from unsafe abortion in Africa (UN Radio 2010). Even when they do not succumb from the unsafe abortion, millions of women and girls in Africa suffer long-term complications such as sterility or disability. The burden of complications is higher in adolescents than in adults as adolescents are more likely to resort to unskilled staff to perform the abortion, sometimes using dangerous methods. They are also more likely to delay seeking and accessing adequate health care services for a safe abortion or if there are complications resulting from the unsafe procedure.

Table 3 Estimated number of unsafe abortions and unsafe abortion rates in developing countries

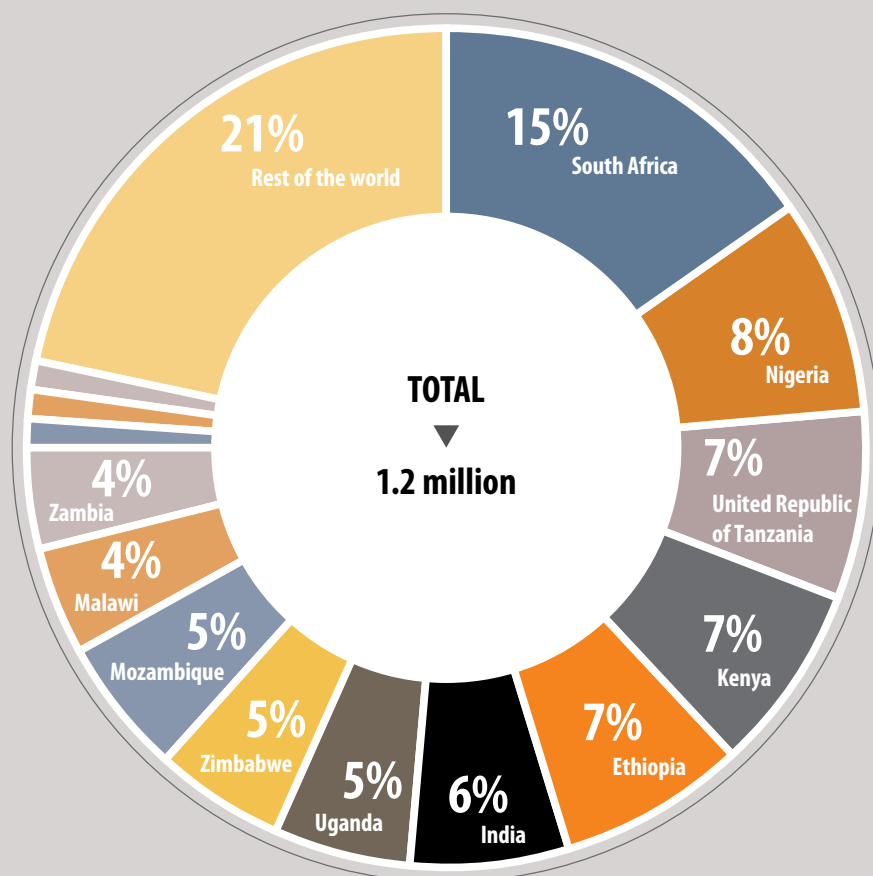
DEVELOPING REGIONS	ANNUAL NUMBER OF UNSAFE ABORTION PERFORMED ON GIRLS AGED 15 TO 19 YEARS	UNSAFE ABORTION RATES PER 1000 GIRLS AGED 15 TO 19 YEARS
Developing countries	3 200 000	16
Africa	1 400 000	26
Asia (excluding East Asia)	1 100 000	9
Latin America and the Caribbean	6 70 000	25

Source: Shah and Ahman 2012

Africa carries the highest burden of adolescent HIV in in the world –Three-quarters of all the HIV cases in young people in the world are in Africa. Females are more than twice as likely as males to be infected and currently account for 70% of all adolescent HIV cases in



Figure 2 Estimated percentage of adolescents aged 10-19 living with HIV in 14 selected high burden countries, 2013



Source: UNAIDS 2013 HIV and AIDS estimated, July 2014

- Half of all adolescents living with HIV and in need of immediate care are in 6 countries - five of them are in the African Region. Fifteen countries account for 80% of all 2.1 million adolescents living with HIV in 2013.
- There are an estimated 430,000 new HIV infections per year among young people aged 15-24 years in Eastern and Southern Africa
- Only 10% of young men and 15% of young women aged 15-24 years in Africa know their HIV status
- AIDS-related deaths are declining rapidly for all age groups, except adolescents - effect of less effort, ineffective strategies and limited scale of HTC implementation and care for adolescents.

the African region. Young girls are more vulnerable to HIV infection because of biological factors, poverty, early marriage, gender inequity, having older sex partners, lack of access to information and sexual and reproductive health services, myths and beliefs about HIV (Kaiser Family Foundation 2002). This vulnerability may increase during humanitarian crises, in conflict settings and emergencies when socioeconomic hardship leads to a high risk of exploitation, sexual abuse, rape and transactional sex (WHO 2009).

Female genital mutilation is decreasing slightly – Across sub-Saharan Africa, there has been only a minor reduction in the overall prevalence of female genital mutilation or cutting (FGM/C). The practice still remains pervasive in many African countries; in 10 African countries, FGM still occurs in over 50% of girls. In more than half of the 29 countries where FGM/C is concentrated, however, significantly lower prevalence levels can be found in the

youngest age group (15-19 years) compared to the oldest age group (45-49 years) indicating a decline in the practice (UNICEF 2013a). Medical complications related to female genital mutilation occur through the woman's "lifespan and commonly include chronic pelvic and urinary infections, severe menstrual pain, and obstetrical complications affecting both mother and baby" (Upvall 2009).

Progress in implementation of ASRHR programmes

In response to the above-mentioned situation, WHO has increased its support to Member States in developing and implementing adolescent health strategies. To date 33 countries have developed adolescent and youth health policies or strategic plans. In addition, 25 countries have developed adolescent friendly health service standards along with implementation plans. As part of WHO's comprehensive approach for prevention and control of cervical cancer, 20 countries in the Region have started the integration of adolescent health interventions (SRH) with human papilloma virus (HPV) vaccination, either nationwide or through demonstration projects. In addition, WHO has proposed a set of indicators that are more specific and tailored to adolescent health in order to strengthen the planning, monitoring and evaluation of adolescent health interventions in the African Region.

Table 4 ASRH policies and programmes - Country progress

POLICIES AND STRATEGIES	STANDARDS AND ACTION PLANS	SRH AND HPV INTEGRATION
Angola, Benin, Botswana, Burkina Faso, Cameroon, Central African Republic, Chad, Comoros, Congo, Côte d'Ivoire, DR-Congo, Equatorial Guinea, Eritrea, Ethiopia, Gabon, Ghana, Kenya, Lesotho, Madagascar, Malawi, Mali, Mauritania, Mozambique, Niger, Sao Tome and Principe, Sierra Leone, South Africa, Swaziland, Uganda, Tanzania, Zimbabwe.	Benin, Burkina Faso, Congo, Côte d'Ivoire, DR-Congo, Eritrea, Ethiopia, Gabon, Ghana, Guinea Bissau, Kenya, Lesotho, Malawi, Mali, Mozambique, Nigeria, Sao Tome and Principe, Senegal, Sierra Leone, South Africa, Togo, Uganda, Tanzania, Zambia, Zimbabwe.	Benin, Cote d'Ivoire, Gambia, Ghana, Liberia, Mali, Niger, Sierra Leone, Senegal Togo, Burundi, Cameroon, Kenya, Madagascar, Malawi, Mozambique, Rwanda, Tanzania, Uganda and Zimbabwe.

Despite commitments contained in plans, policies, programmes and declarations, few countries have moved from sound policies and strategies to large scale and sustained ASRH programmes. In the African context negative social, cultural, economic and legal factors continue to threaten the lives and health of a large number of adolescents. The effective realization of these commitments is dependent on:

- The political will required to promote agendas and facilitate processes that may have difficult and contentious elements;
- Enhanced capacity of educators and health practitioners to implement youth-friendly health and education services;
- The availability of sustainable resourcing to ensure effective national roll out of key education and health programmes for young people;
- Effective monitoring and evaluation of education and health programmes in order to assess impact in an ongoing manner and to ensure optimal value for money in resource-constrained environments.

In the last five years, important opportunities to step up efforts to meet the needs and fulfil the rights of adolescents have emerged in the Region. For instance, the African Union

(AU) launched the Campaign to End Child Marriage in Africa. Africa is home to 15 out of 20 countries with the highest rates of child marriage. The two-year campaign aims to accelerate efforts to end child marriage across the continent. In November 2012, ten Francophone countries committed to advancing the sexual and reproductive health of adolescents in the action programmes of Priority Solidarity Fund / Muskoka. In addition, on 7 December 2013, Ministers of Health and Education from 20 countries in East and Southern Africa (ESA) adopted the ESA Commitment. The Commitment is a strategic tool that, for the first time, brings together Ministries of Education and Health to strengthen HIV prevention efforts and foster positive health outcomes by advocating for access to quality, comprehensive sexuality education as well as sexual and reproductive health services for young people in the Region. The momentum created at global and regional levels has fostered better coordination and mobilised more resources to strengthen country-level action.

Discussions and recommendations

1 Address the underlying determinants of child marriage – In the African Region, adolescent pregnancy is not a deliberate choice for adolescent girls. It is a result of various underlying and interconnected factors including: poverty, exclusion, marginalization, communities' and families' acceptance of child marriage and inadequate efforts to keep girls in school.

In addition to laws adopted in many countries, there is a need to address the underlying determinants of child marriage as well as the significant factors that contribute to perpetuating this practice in the Region. Such factors include: Gender inequity and inequality; social pressures; poverty; exclusion from educational and employment opportunities; marginalization; and stereotypes about adolescent girls.

2 Sensitize and educate all role players

– There is also the need to undertake various actions aimed at sensitizing and educating parents, families and communities where the prevalence of

child marriage remains high.

3 Multisectoral action – Preventing and reducing adolescent pregnancy needs multisectoral strategies and interventions tailored to adolescent needs. Men, boys and girls must be part of the solution.

Preventing unsafe abortion in the region requires action involving several role-players including government, civil society, communities, families, parents and educators. Illustrative examples of these actions include: availability of and access to sexual and reproductive health services; access to accurate information regarding sexual and reproductive health; empowerment of girls to make decisions in life; and enrolment and retention of girls in school.

4 Invest in addressing adolescent HIV

– HIV infection in adolescents should remain high on the development agenda in the African Region and receive the necessary investment to deal with this crucial issue in a comprehensive manner. Countries need to address key issues related to this particular age group such as delayed sexual debut, access to accurate information and quality health services, HIV prevention, treatment, care and support.

1.3 Plenary presentations

1.3.1 UNICEF: Adolescent Sexual and Reproductive Health in Africa and Perspectives

This presentation, by **Dr Christine Kabore, Deputy Representative, UNICEF Congo Brazzaville**, provided an overview of the opportunities and challenges facing ASRHR in Africa.

Whilst there has been some progress towards improving ASRH in Africa there are still several challenges to be overcome. The UNICEF 2013 stock taking report found that preventive behaviour is improving among boys aged 10-19 years; more than two thirds of adolescent males with multiple partners reported using a condom the last time they had sex. However, similar data among girls aged 15-19 show lower condom utilization rates of below 30-40%. The level of knowledge of HIV/AIDS amongst

adolescents also remains low: 26% of girls aged 15-19 and 32% of boys of the same age had acceptable knowledge levels (UNICEF 2013).

Despite the social resistance, awareness raising activities coupled with the strengthening of legislative reforms has led to decreases in harmful cultural practices, such as female genital mutilation, in most countries. On the other hand, child marriage continues to be a reality in many countries, particularly in the Sahel.

There have been a number of high-level commitments to ASRH at Regional, Sub-regional and country levels. Examples of these include: the Maputo Plan of Action signed by the heads of States and endorsed by the African Union (AU); Education Programs in family life; AU and WHO commitment to end preventable maternal and child deaths in Africa; and the East and Southern African (ESA) commitment to strengthen HIV prevention efforts and foster positive health outcomes by advocating for access to quality CSE as well as SRH services for young people in the Region.

However, despite growing momentum for ASRH, there are still systemic and socio-cultural constraints that disadvantage and discriminate against adolescents in the Region. Married adolescents can access ASRH services with no discrimination, but may face issues related to low decision-making powers. Unmarried adolescent girls are at high risk of unwanted pregnancies with potential negative consequences such as unsafe abortion, abandonment of the newborn and family rejection.

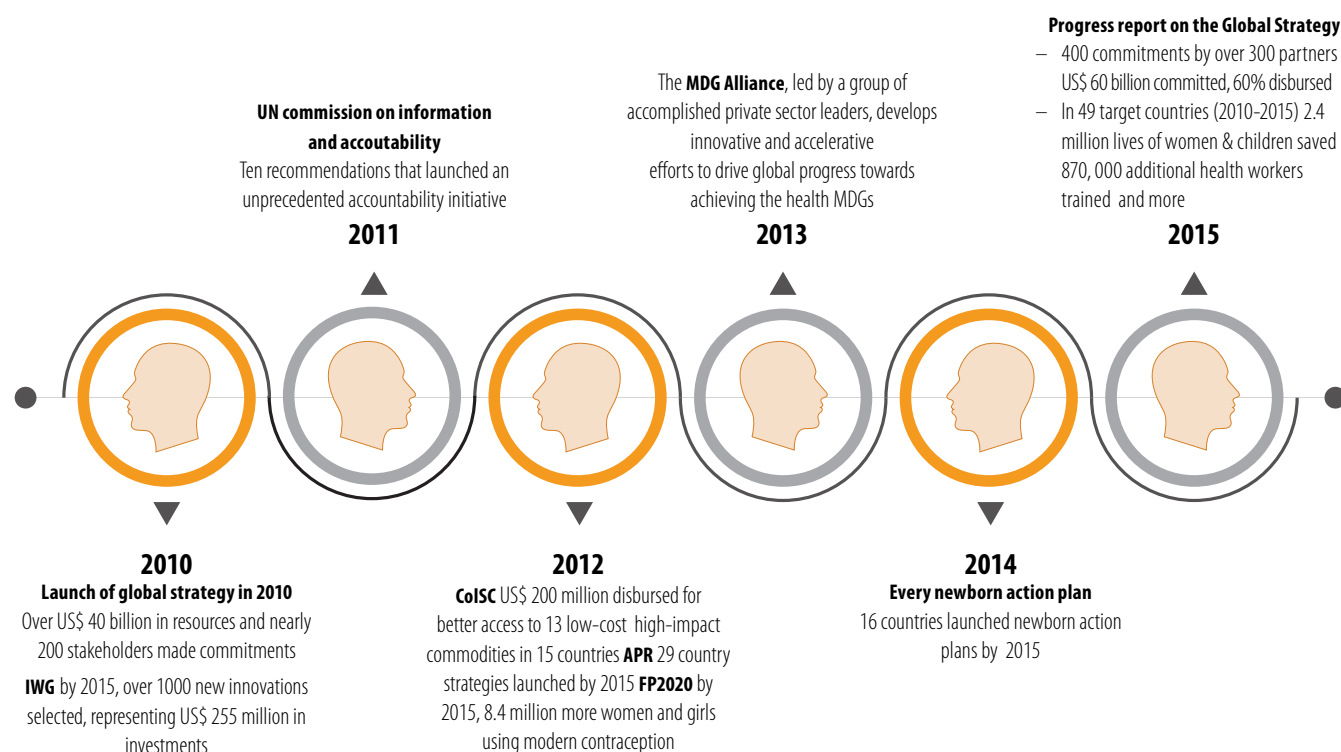
Adolescent girls and boys are at high risk of sexually transmitted infections (STIs), including HIV, which may make them subject to stigma and discrimination. Available data on HIV prevalence among adolescents indicate that adolescent girls continue to bear the brunt of the burden in Sub-Saharan Africa.

The post-2015 development agenda should advance SRHR for all women, men and young people by accelerating implementation of universal access to quality, comprehensive sexual and reproductive information, education and services with emphasis on the following strategies:

Figure 3 UNICEF's priority intervention areas for ASRHR post-2015



Figure 4 Results and timelines of the EWEC Strategy



- **Prevention** through access to family planning and a wide range of contraceptives, counseling and services related to maternal health, and STIs including HIV;
- **Access** to affordable supplies;
- **Integration of services**, especially the integration of HIV into other SRH services; and
- **Adequate responses** to child marriage, violence against women and girls and sexual abuse.

UNICEF’s response will optimize adolescent health and wellness through a range of high impact interventions, illustrated in Figure 3 above. These include the following activities:

- Strengthen and scale up interventions that are more tailored to ASRH with a focus on vulnerability and sexual behaviour, early and unwanted pregnancy, and STIs including HIV/ AIDS;
- Strengthen evidence-based interventions targeting the most exposed and vulnerable adolescents to HIV; and
- Optimize access to HIV prevention, treatment and care services in the context of the ALL-In Initiative to end AIDS among adolescents.

UNICEF aims to increase the reach, coverage and impact of adolescent prevention, treatment and care programmes through fostering innovative approaches that include:

- Promoting CSE by adapting the terminology to the socio-cultural context;
- Promoting the use of relevant platforms, such as hot lines, U-report (Ureport is a free SMS-based system that allows young Ugandans to speak out on what is happening in communities across the country, and work together with other community leaders for positive change. Ureport is made up of: Weekly

SMS messages and polls to and from a growing community of Ureporters), e-Health and m-Health, to inform and educate adolescents;

- Optimizing community based approaches for and with adolescents themselves;
- Parent and teacher involvement (self-supporting groups);
- Promoting new initiatives and cross-sectoral programme synergies that will optimize results for adolescents; and
- Conducting data-driven advocacy to optimize resource allocation, including resource gap mapping and expenditure tracking, to ensure effective, efficient investments towards ending preventable death among adolescents.

1.3.2 UNFPA: Shaping the future for healthy women, children and adolescents

This presentation outlined the new UNFPA Global Strategy for Women’s, Children’s and Adolescent’s Health. **Laura Laski** and **Danielle Engel** provided inputs.

The figure above represents the progress, results and timelines of the Every Woman Every Child (EWEC) Strategy.

The new strategy builds on key elements of the former Every Woman Every Child Strategy including:

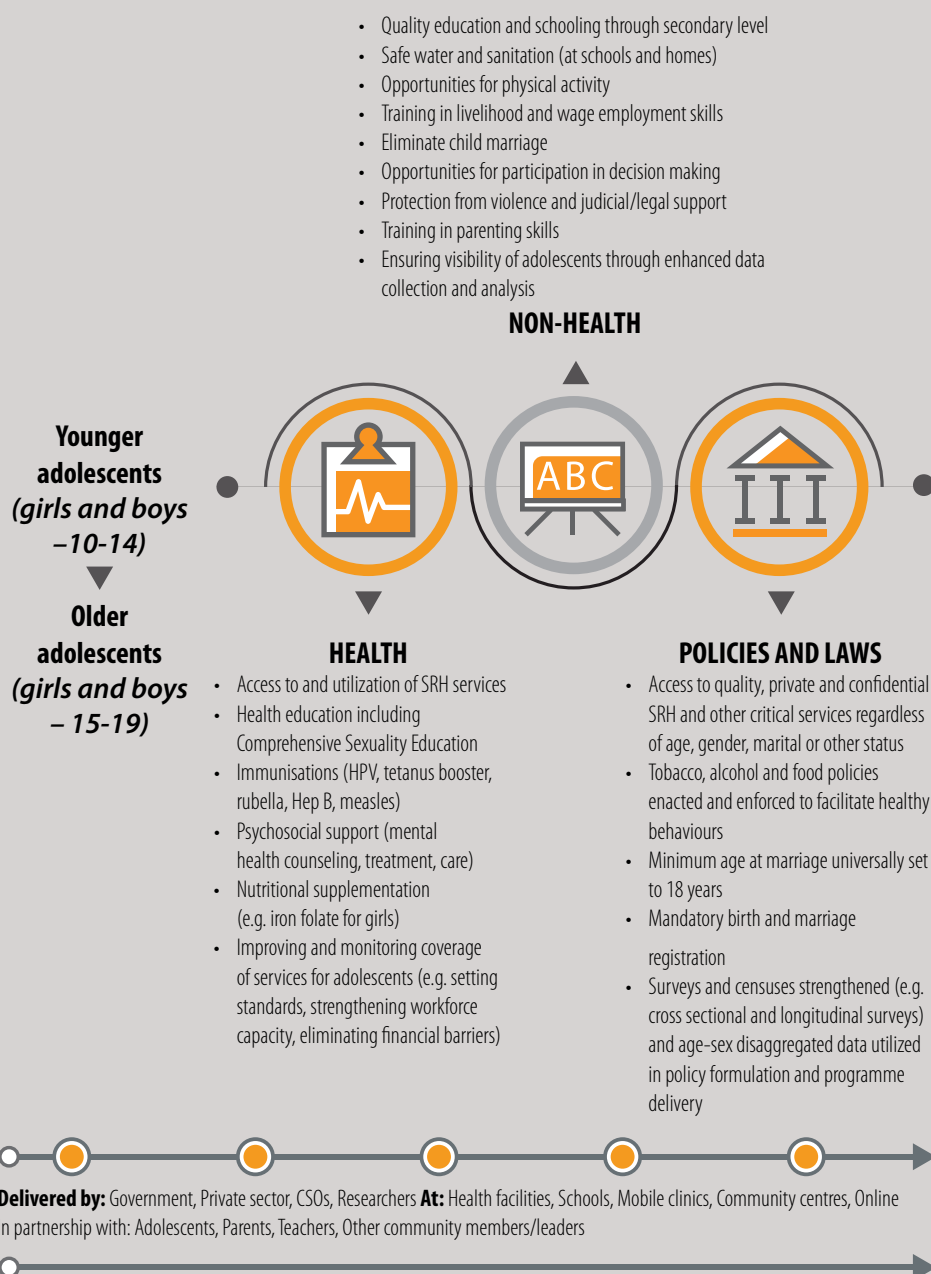
- Support for country-led health plans;
- Integrated delivery of health services and life-saving interventions and commodities;
- Health systems strengthening;
- Innovative approaches; and
- Improved monitoring and evaluation (M&E).

The new Global Strategy is inspired by the Sustainable Development Goals (SDGs). It is strongly embedded in a human rights approach and specifically addresses humanitarian settings and inequities. An important introduction is a new focus on Adolescent Health (AH).

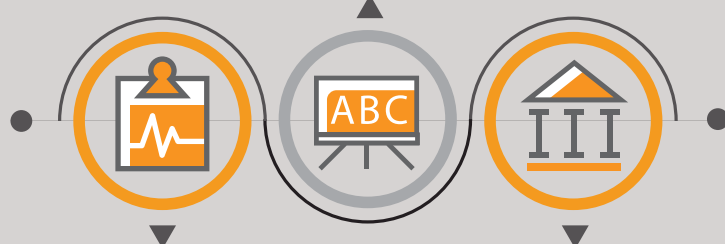
Adolescence is characterized by rapid biological, emotional and social development. It is a time during which every person has the potential and right to develop the capabilities necessary for a productive, healthy and satisfying life. Adolescence is also a period fraught with many health challenges as illustrated by the following facts and figures:

- 1.3 million adolescents die every year, mostly from preventable causes;
- Road traffic injuries are the leading cause of death;
- The two leading causes of death for 15-19 year old girls are suicide and complications during pregnancy and childbirth;
- Other main causes of adolescent deaths include HIV, lower respiratory tract infections (LRTI) and interpersonal violence;
- Around 120 million girls under the age of 20 (approximately 1 in 10) have been victims of sexual violence;
- Every year, 3 million girls aged 15-19 years undergo unsafe abortions;
- 2.1 million adolescents live with HIV; 64% of new infections in 15-19 year olds occur in girls;
- 15 million girls are married before the age of 18 years;
- 70% of preventable adult deaths are linked to risk factors that start in adolescence. These include smoking, poor nutritional habits and insufficient physical activity.

Figure 5 Priority interventions for adolescents



- Quality education and schooling through secondary level
- Safe water and sanitation (at schools and homes)
- Opportunities for physical activity
- Training in livelihood and wage employment skills
- Eliminate child marriage
- Opportunities for participation in decision making
- Protection from violence and judicial/legal support
- Training in parenting skills
- Ensuring visibility of adolescents through enhanced data collection and analysis



- HEALTH**
- Access to and utilization of SRH services
 - Health education including Comprehensive Sexuality Education
 - Immunisations (HPV, tetanus booster, rubella, Hep B, measles)
 - Psychosocial support (mental health counseling, treatment, care)
 - Nutritional supplementation (e.g. iron folate for girls)
 - Improving and monitoring coverage of services for adolescents (e.g. setting standards, strengthening workforce capacity, eliminating financial barriers)
- POLICIES AND LAWS**
- Access to quality, private and confidential SRH and other critical services regardless of age, gender, marital or other status
 - Tobacco, alcohol and food policies enacted and enforced to facilitate healthy behaviours
 - Minimum age at marriage universally set to 18 years
 - Mandatory birth and marriage registration
 - Surveys and censuses strengthened (e.g. cross sectional and longitudinal surveys) and age-sex disaggregated data utilized in policy formulation and programme delivery

“How we meet the needs and aspirations of *young people* and enable them to enjoy their rights will define our common future.”

Dr. Babatunde Osotimehin, Executive Director and Under-Secretary-General of the United Nations

In order to realize the health and wellbeing of adolescents and protect their human rights, countries need to adopt holistic health policies. These should include programs to educate them about, and help them build the good judgment and decision-making skills required not only to prevent injuries, violence, self-harm, and non-communicable diseases (NCDs), but also to promote good SRH outcomes, as well as other crucial aspects of positive physical and mental health and development.

Figure 5 alongside lists the priority interventions that should be implemented

by various sectors in order to facilitate the health and well being of adolescents and young people.

1.3.3 UNESCO: Africa's progress and challenges regarding Adolescent Sexual and Reproductive Health

This presentation, delivered by **Dr Victoria Kisaakye Kanobe, UNESCO Regional Support Team for HIV and Health Education in Eastern and Southern Africa**, describes the status of ASRH services in Africa and highlights areas of notable progress as well as significant setbacks.

The ICPD recommended that the reproductive health and rights of adolescents and young people be addressed through the promotion of responsible and healthy reproductive and

Table 5 Areas of notable progress and setbacks in ASRHR in Africa

sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group. Countries were encouraged “to ensure that programmes and attitudes and practises of health-care providers do not restrict youth access to and utilization of the services and information they need. These services must safeguard the right of adolescents to privacy, confidentiality, respect and informed consent, while respecting cultural values and religious beliefs as well as the rights, duties and responsibilities of parents” (UNFPA 1994).

Government leadership commitments such as the ESA Ministerial Commitment (2013) as well as multi-sectoral partnerships and approaches to scale up CSE and ASRH services for young people (YP) have contributed to progress in ASRHR in Africa. On the other hand the process has been hampered by factors such as programmes and data collection systems that have focused on either children or adults, excluding adolescents as a specific target group. This has created an information gap. Table 5 below lists areas of notable progress as well as notable setbacks in ASRHR within the Region.

NOTABLE PROGRESS

Increased commitment by governments and stakeholders to information, education and communication (IEC) to address ASRH needs

International: Development partner initiatives e.g. Dreams, All-in, Fast track pregnancies, STIs, including HIV among adolescents and young people
Regional: Maputo Plan of Action (2006) signed by 48 countries and focused on the Operationalisation of the Continental Framework for Action on Sexual and Reproductive Health and Rights; the Dakar Framework for Action on Education for All (EFA); Abuja Declaration and Framework for Action on HIV/AIDS; the African Youth Charter, the Millennium Declaration and the African Union Second Decade of Education Plan of Action; ESA Ministerial Commitment (2013) by the Ministries of Health (MOH) and Ministries of Education (MOE), from 20 countries to reinvigorate and strengthen HIV prevention efforts and foster positive health outcomes by advocating for access to quality, CSE as well as SRH services for young people in the ESA region.

National: Development of National Reproductive Health Strategies, Policies and frameworks to guide planning, standardization, integration, implementation, and monitoring and evaluation (M&E) of SRH services including those for Youth and Family Services (YFS) for Young People (YP).

Increased delivery and coverage of quality CSE through various modalities and settings

12 countries in ESA report having integrated CSE in primary education - mainly life skills education (LSE). It is an examinable subject in 8 countries;

12 countries in ESA report having integrated CSE in secondary education; it is an examinable subject in 10 countries;

CSE integration is in process in 6 other countries.

It is important to note that progress has been very uneven across countries, with large gaps, particularly, but not only, in West Africa.

In the context of the post-2015 agenda, several initiatives are planned that focus on ASRH and HIV Prevention for young people. UNESCO has identified the following priority actions:

Create an enabling legal environment: Harmonise laws and legislation and ensure national coalitions for regulatory reforms, where necessary, to remove inconsistencies and ambiguities that may create barriers to access CSE and SRH services for adolescents.

Improve the quality of SRH services and CSE: Increase access to quality,

comprehensive and integrated SRH

information, education and communication (IEC) to address ASRH needs

Adolescent-friendly services, including the basis for prevention of unintended pregnancies, STIs, including HIV among adolescents and young people to realisation of the demographic dividend. A country with a high potential to sex for males and young people in Lesotho and Swaziland.

Although 35 countries in Africa have adopted laws on the minimum legal age of marriage, many families and girls themselves do not know that these laws exist, and their enforcement is often lax. In many countries there are also loopholes that impede protection. For example, in Democratic Republic of Congo (DRC) a young girl can marry at a very young age and parental consent even though the legal age is 18 years. In Mozambique and Uganda, marriageable age is 18 years without parental consent, but can also take place at a younger age.

Lack of targeted interventions for YFP - Service Providers' biases and attitudes towards young people's sexuality and services; address gender inequality in terms of beliefs, attitudes, and norms. There is a growing body of evidence supporting their issues are not well understood by the service providers who end up becoming a barrier and restrict adolescents from accessing the services. CSE with a gender and rights-based curriculum approach.

It is important to understand that adolescents are not homogeneous - a growing body of evidence supporting their issues are not well understood by the service providers who end up becoming a barrier and restrict adolescents from accessing the services. CSE with a gender and rights-based curriculum approach.

2. Scale up access to CSE and ASRH services with meaningful participation of adolescents in the programme management cycle, beginning with identification of needs right through to programme evaluation
3. Design programmes to target and collect data on the different age categories: 10-14 years and 5-19 years
4. Harmonize laws and policies for young people's services to improve their access to CSE and ASRH services and eliminate GBV

NOTABLE SETBACKS

economic productivity that occurs when people are able to access FP commodities

economic productivity that occurs when people are able to access FP commodities

economic productivity that occurs when people are able to access FP commodities

economic productivity that occurs when people are able to access FP commodities

economic productivity that occurs when people are able to access FP commodities

1.3.4 UN Women: How much progress has the Region made on ASRH over the past 20 years?

This presentation by **Ms Molline Marume, Programme Specialist: Gender and HIV/AIDS UN WOMEN**, takes stock of progress over the past 20 years and highlights the way forward for ASRH in the next five years.

While there is progress in making SRH services and a variety of modern FP methods available, many disadvantaged women and adolescents still lack access to SRH information and services, FP services and post abortion care. As a result of this limited or lack of access, a high proportion

of women and adolescents continue to suffer death and disabilities as a result of pregnancy and childbirth.

On the other hand, the Region has made some progress in addressing early marriage, early motherhood, as well as the underlying determinants of child marriage. Significant enabling factors that contribute to perpetuating this practice in the Region include gender inequity and inequality, social pressures, poverty, exclusion from educational and employment opportunities, marginalization and stereotypes regarding adolescent girls. There are dramatic variations in the minimum marriageable age within the Region. Some countries, such as Equatorial Guinea, have a marriageable age limit of 12 years of age, while in Botswana, Namibia, Rwanda, Sierra Leone, and Zambia this is 21 years of age.

Looking back: What has hindered progress in ASRH in Africa?

Many structural and socio-cultural factors continue to hinder progress on ASRH within the Region. These include:

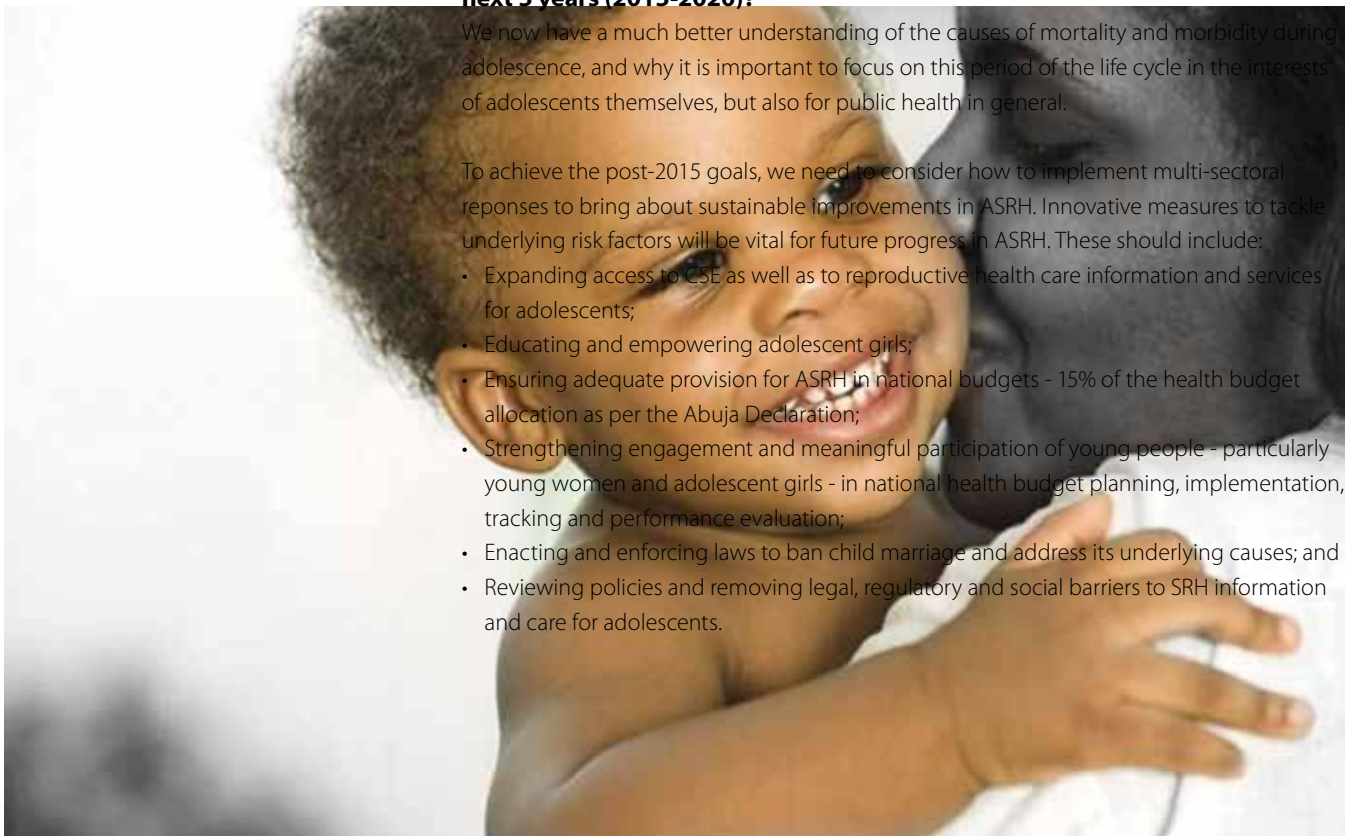
- **Lack of resources** – limited budget allocations, particularly the amounts assigned to ASRH;
- **Cultural and social norms** especially gender based inequity and high levels of gender based violence;
- **Poor governance** leading to low economic growth;
- **Donor-dependent health budgets**, which often shape priority actions in health. As an example, there is donor money for HIV hence the focus on HIV and little or no funds for ASRH including FP.

Looking ahead: What should be the main ASRH priorities for Africa in the next 5 years (2015-2020)?

We now have a much better understanding of the causes of mortality and morbidity during adolescence, and why it is important to focus on this period of the life cycle in the interests of adolescents themselves, but also for public health in general.

To achieve the post-2015 goals, we need to consider how to implement multi-sectoral responses to bring about sustainable improvements in ASRH. Innovative measures to tackle underlying risk factors will be vital for future progress in ASRH. These should include:

- Expanding access to CSE as well as to reproductive health care information and services for adolescents;
- Educating and empowering adolescent girls;
- Ensuring adequate provision for ASRH in national budgets - 15% of the health budget allocation as per the Abuja Declaration;
- Strengthening engagement and meaningful participation of young people - particularly young women and adolescent girls - in national health budget planning, implementation, tracking and performance evaluation;
- Enacting and enforcing laws to ban child marriage and address its underlying causes; and
- Reviewing policies and removing legal, regulatory and social barriers to SRH information and care for adolescents.



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SESSION 2: Lessons learned from implementation of ASRH in the 20 years since ICPD

2.1 Comprehensive sexuality education

Key messages from the Journal of Adolescent Health Supplement

CSE: Emerging trends in evidence and practice

Evidence from research:

- CSE does not foster early or increased sexual activity
- CSE programmes that include, and effectively address, gender inequality and power relations are more likely to reduce unwanted pregnancy and STIs

Lessons from implementation experience:

- Only a small number of countries have scaled up CSE
- Even in these places vulnerable adolescents have not been reached
- In many places teachers find it difficult to conduct CSE

Implications for action:

- Scale up school-based programmes with serious investments to strengthen teachers' capacity to deliver CSE that is participatory and generates critical reflection and dialogue about gender, power, sexuality and rights
- Prioritize the most vulnerable adolescents, as well as students in upper primary grades because in some places many girls do not make the transition to secondary school

Implications for research:

- Conduct implementation research to identify and overcome barriers to the delivery of CSE programmes in different contexts
- Evaluate health and social outcomes of CSE programmes, not just self-reported sexual behaviours

2.1.1 UNESCO: Lessons learnt from CSE implementation in Africa
Victoria Kisaakye, Patricia Machawira and Joanna Herat provided these perspectives on CSE implementation in Africa on behalf of **UNESCO**.

Understanding what we mean by CSE is a critical first step to ensuring that young people can benefit from it. Sexuality education is an age-appropriate, culturally relevant approach to teaching about sex and relationships by providing scientifically accurate, realistic, non-judgemental information. Sexuality education provides opportunities to explore one's own values and attitudes and to build decision-making, communication and risk reduction skills about many aspects of sexuality. CSE is not only an essential part of a good school curriculum but also an essential part of a national comprehensive AIDS response as it provides a platform for HIV prevention. SE is most effective when provided from a gender and rights perspective. An empowerment approach to CSE empowers young people to protect their own health (Haberland 2015).

School-based CSE is increasingly recognized as an effective approach within the context of HIV and pregnancy prevention. Fonner's review of 63 studies published last year (2014) concluded that comprehensive school based sex education (SBSE) is an effective strategy for reducing HIV-related risk. CSE does NOT encourage young people to have sex. In fact, many CSE programmes have significant, long term effects on knowledge, attitudes, self-efficacy and intentions to change behaviour. Recent data on behavioural outcomes demonstrate that most programmes have a positive impact on one or more sexual behaviours including: (1) Increased self efficacy to refuse sex; (2) Delayed initiation of intercourse or increased abstinence; (3) Reduced number of sexual partners; (4) Increased use of condoms; or (5) Reduced unprotected sex; and (6) Increased use of contraception (Fonner 2014).

Whilst we do not have evidence on the impact of CSE programs on biological outcomes, the evidence from Fonner's review as well as the UN review published in the international technical guidance in 2009, points very strongly towards healthy

behaviour development, self-efficacy and lower risk sexual practices (UNESCO 2009).

Based on thorough assessments in over 25 countries across the African Region we have learnt a considerable amount about the way CSE is, or is not, being delivered to children and adolescents.

- HIV prevention and some health education are often taught through Life Skills Education programmes and most countries have achieved fairly good coverage. However, the quality and curriculum content remains weak.
- In a Region with high rates of sexual HIV transmission and early pregnancy, sexuality issues are only partially included or not included in LSE and therefore not covered adequately.
- In particular, we know that key aspects of sex and sexual health are often lacking i.e. information about reproduction, STIs, abortion and where to access condoms or other SRH services.
- Educators are not equipped to deal with sexuality issues and therefore they are not comfortable talking to students about sexuality (UNESCO 2012).

Creating an enabling environment for the delivery of CSE is critical for successful scale-up of CSE programmes. Situation analyses using tools that actively involve multiple stakeholders allowing them to understand the results, is a very helpful first step in building support and moving towards strengthened CSE provision. Engaging young people as well as communities and parents helps to ensure that programmes are based on the real needs of people who will benefit from them, and that there is ample opportunity to discuss and consider concerns or opposition that may arise. Many teachers or principals may be anxious that teaching CSE is 'not allowed' or not appropriate. If there is a national policy, and clear high-level political support for this topic, rolling it out in the classroom becomes a more straightforward task.

At the technical level, there are many tools and resources that can be used to support development of a high quality programme that will really have an impact on young people's health. Assessment of the current curriculum content will allow stakeholders to recognise what subjects are already being taught, what approaches are already being used and to note what gaps exist and what needs to be strengthened. Curricula can be updated in line with international standards such as the UN Technical Guidance and should also reflect local realities – for example if inter-generational relationships are a key risk factor for girls, this topic can be integrated into the curriculum or learning resources. All countries in Africa should now invest heavily in teacher education because teachers are the key to successful CSE - they manage the content and the classroom dynamics and have to be equipped to deal with a very sensitive topic. This requires pre- and in-service training; allowing adequate space in the curriculum so that other topics don't crowd out the subject; as well as ensuring that there is appropriate support from school management to deliver these lessons, and from the school community (notably parents and guardians). For CSE training to be successful, it will need to address the sexuality of teachers themselves and help them clarify their own values before they can begin to deal with teaching learners on the subject. The influence of religion and

culture was cited in a recent UNESCO study as a key factor which influences teacher willingness, or unwillingness, to talk about sensitive topics. Monitoring implementation progress and outcome can be done through existing national systems, although more nuanced data can be generated from specifically commissioned evaluations. Finally, education must be connected to the provision of health services. Effective partnerships between the health and education sectors are important for the provision of effective SRH services after CSE has created the increased demand.

Key lessons

- Scale has not yet been achieved in implementation of school-based HIV prevention education;
- Mechanisms to reach marginalised adolescents are needed. Marginalized adolescents who are at higher risk of HIV, gender based violence and early pregnancy are not being targeted as required;
- There is a need to develop more structured and robust out of school programmes to reach those large numbers of adolescents not enrolled in school;
- Start in primary school- SE must start early so that children develop healthy behaviours and attitudes. SBSE programmes limited to secondary level come too late for many young people as some children go through puberty or start having sex whilst in primary school and many children will have already dropped out before reaching secondary school; and
- Integrating content on Gender and Rights into CSE and other subjects will help make CSE more effective by ensuring that education is relevant to the drivers of inequality and vulnerability.

2.1.2 UNESCO: Progress on the ESA Ministerial Commitment in 21 countries

Dr Victorai Kisaakye Kanobe, Regional Programmes Coordinator, HIV and Health Education, in ESA delivered this presentation on behalf of UNESCO.

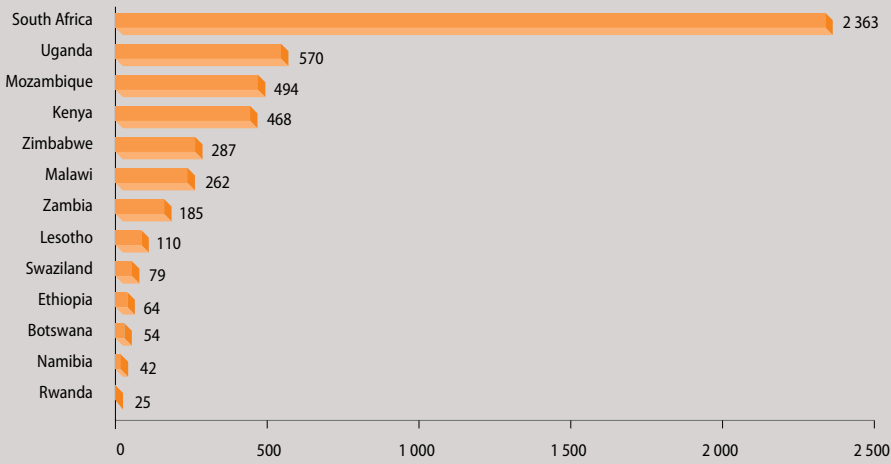
The ESA Commitment responds to a number of key imperatives, which include:

- **High HIV infections rates** among 15-24 years olds provided the impetus to guide young people around issues of sexuality and HIV prevention. Figure 6 below shows the estimated number of new HIV infections occurring per week among young women aged 15-24 years in ESA in 2012 (UNAIDS 2013).
- **Low levels of comprehensive knowledge on HIV** despite the fact that since the 1990s HIV-related education or LSE have been included in the school curricula of most countries. On average, less than 40% of YP have basic information about HIV - 41% of young males and 33% of young females.
- **High levels of teenage pregnancy** – The adolescent fertility rate in the ESA Region is 108.2 per 1000 live births, which is more than double the global rate. Figure 7 below shows the teenage pregnancy rate in 15-19 year olds from selected African countries. Rates are especially high in Zambia, Uganda, Malawi, and Zimbabwe. In Malawi, for example, more than 50% of girls will have given birth by the age of 20 years. Pregnancy levels are a good reflection of unprotected sex.
- **Persistent and harmful gender inequality and human rights violations** - Life skills programmes as they are currently provided are failing in most instances to equip children with the skills that they need in life. HIV is not the only issue that adolescent girls identify as a challenge; in fact they are often more concerned about pregnancy, violence or day to day economic, family and social issues.
- **Inadequate education on sexuality, HIV/STI prevention and risk reduction** – data from the Southern and Eastern Africa Consortium for Monitoring Educational Quality (SACMEQ) indicate that teachers have high levels of

knowledge on HIV BUT there are low levels of comprehensive knowledge on HIV amongst learners. Only 7% of 6th grade pupils reached the desirable level of knowledge.

- **Poor linkages and referrals to SRH services** result in the SRH needs of Young People Living with HIV remaining largely unmet.

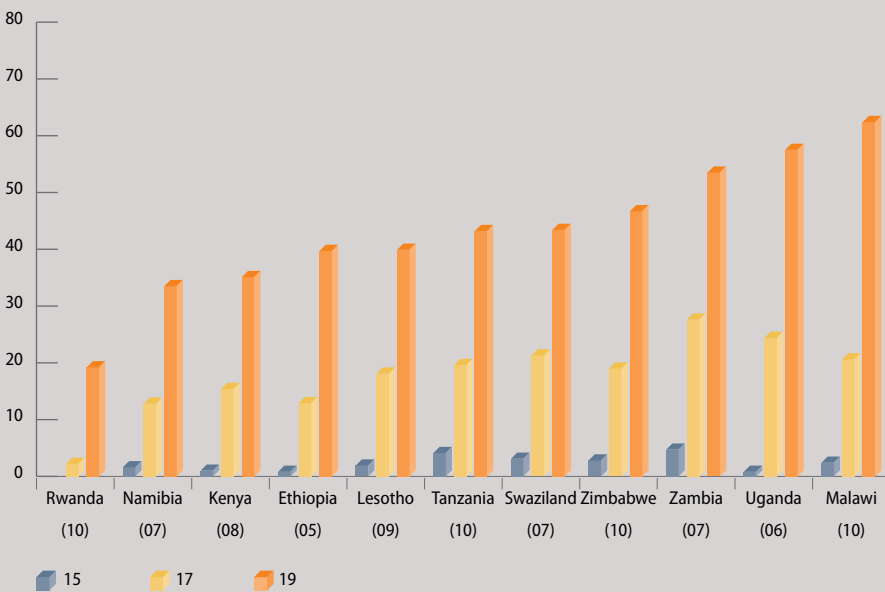
Figure 6 Estimated HIV incidence in young women in ESA



Estimated number of new HIV infections per week among young women aged 15 – 24 years in East and Southern Africa, 2012.

Data source: UNAIDS 2013

Figure 7 Adolescent fertility in 15-19 year olds in ESA



School attendance has been shown to reduce sexual risk behaviour as well as HIV incidence. A 2005 study conducted in Rakai, Uganda credited increased primary education for reducing new HIV infections by 29% among 15-19 year old girls. Research also indicates that youth who attend school are less likely to initiate sex at an early age compared to non-attenders and are more likely to use contraception or condoms than youth who are not in school.

The ESA Commitment is a catalyst for accelerating the scale up of CSE in the ESA Region. It was endorsed by 20 ESA Countries in December 2013 and is supported by the UN, development partners and civil society. UNAIDS chairs the High Level Group (HLG) and the Technical Coordinating Group (TCG) and UNESCO performs the Secretariat function. The Commitment document lists nine targets of which three are process targets for 2015 as well as a mix of behavioural and process targets to be achieved by 2020.

Table 6 ESA Commitment targets for 2015 and 2010

2015	2020
<ul style="list-style-type: none"> • A good quality CSE curriculum framework is in place and being implemented in each of the 20 countries; • Pre-and in-service SRH and CSE training for teachers, health and social workers are in place and being implemented in all 20 countries; and • By the end of 2015, decrease by 50% the number of adolescents and YP who do not have access to youth friendly SRH services, including HIV, that are equitable, accessible, acceptable, appropriate and effective. 	<ul style="list-style-type: none"> • Eliminating all new HIV infections amongst adolescents and YP aged 10-24 years; • Increase to 95% the number of adolescents and YP, aged 10-24 years, who demonstrate comprehensive HIV prevention knowledge levels; • Reduce early and unintended pregnancies among young people by 75%; • Eliminate GBV; • Eliminate child marriage; and • Increase the number of all schools and teacher training institutions that provide CSE to 75%.

Progress in implementing the ESA Commitment, 2013

Since the endorsement of the Commitment, the focus has shifted to action at a country level. Government ownership and implementation progress varies from country to country. From December 2013 countries started developing multi-sectoral work plans to meet the commitment targets. A Regional Accountability Framework (RAF) was developed to support Regional Economic Commissions (REC), to track country progress. The RAF was launched together with the re-launch of the Commitment website country progress pages where individual country progress will be tracked.

Advocacy for the ESA Commitment at Global, Regional and Country levels – Advocacy has focused on reducing teenage pregnancy, GBV and child marriage using a variety of platforms e.g. SADC Ministers of Education conference in collaboration with Population Council to discuss the Education Sector Response to Teenage Pregnancy; Regional Study on Gender, Diversity and Violence in Schools in five Southern African Countries commissioned in June 2014, aimed at generating evidence that will assist governments, and other key stakeholders develop educational policies and practices that promote safe schools for all young people. A regional stakeholder consultative meeting targeting 60 people is tentatively scheduled for the 27th – 28th August 2015.

There has been notable engagement of young people and civil society. However, engagement of RECs has been rather difficult.

Development of a Regional Accountability Framework (RAF) – The RAF will serve as a country-reporting template and is the main instrument that RECs will use to monitor progress. Engagements with Education International will explore how teacher unions

can support implementation of the accountability framework.

All countries in SADC, as well as Kenya, Rwanda and South Sudan were trained on the Global M&E Framework and how it can be integrated into the Education Management Information system (EMIS). All SADC countries are integrating HIV and HIV indicators into the EMIS. As a result the following countries, namely, Botswana, Democratic Republic of Congo (DRC), Lesotho, Namibia, Seychelles, South Sudan, Swaziland, Tanzania and Zambia will start reporting against the indicators in 2015. Another four of the networking countries - Angola, Botswana, South Africa and Zimbabwe - set 2016 for reporting on the indicators

Creation of an enabling environment

– efforts to create a supportive environment for implementing the Commitment include: harmonization of the legal environment on ASRH in ESA; Development of policies and strategic frameworks; resource mobilization; and coordination of joint work plans to achieve the ESA commitment targets.

Development of a vibrant communications strategy for the ESA Commitment

Process – the strategy includes the use of social media, website, ESA Commitment 2014 Annual report, calendars and other promotional materials.

Provision of technical support towards meeting the ESA commitment targets

– technical assistance has been provided to support a number of activities such as: CSE curriculum integration and delivery; support to teacher training; mainstreaming of core HIV indicators into EMIS; use of technology for enhancing CSE delivery; community engagement around CSE, including work with parent-teacher associations (PTAs) and School Management Committees (SMC); the education sector response to teenage pregnancy; Sexuality Education Review and Assessment Tool (SERAT); review of curricula; roll-out of CSE radio lessons in Lesotho to cover grades not reached by the current syllabus; strengthening or development of comprehensive school health policies; and launch of a Regional study to assess education sector responses to school-related gender based violence (SRGBV).

Support for development of curricula and teaching and learning materials – areas of curriculum support provided include CSE curricular revision; peer review of developed curricula; development of teaching and learning materials; and development of scripted lesson plans. The scripted lesson plans are a set of 15 core lesson plans, aimed at learners aged 9–15 years, focused on topics that may be particularly challenging, and where available resource material is lacking, and/or is difficult to develop. They provide a Regional resource with some selected lesson plans that teachers can adapt and use to supplement their existing curricula.

Teacher training – support to **pre-service** training includes working with Advocates for Youth on the development of the Pre-service Teacher Education Module on CSE that is aligned to the in-service module; Training of trainers (TOT) for pre-service teacher education who will then cascade the training to teacher educators and university lecturers. **In-service** teacher training is being rolled out in at least 10 countries with UNESCO support. An on-line in-service module was pre-tested in Swaziland and South Africa and provided useful feedback on the content gaps and areas for improvement. The module will be revised based on the feedback and UNESCO will work with SADC on issues related to accreditation of the course.

Use of technology in CSE scale up – Partnership with i-School in Zambia has reached more than 81 000 children and resulted in enhanced learning. The model maps the curriculum content and links these with associated teacher lesson plans. Similar partnerships are being explored in Lesotho and Botswana.

Community engagement on CSE – support includes development of a community service organization (CSO) and youth

engagement strategy in collaboration with UNAIDS and community engagement materials targeting parents, community leaders, religious and traditional leaders as well as young people. A radio and TV series aimed at mobilizing communities to support CSE, piloted in 2014 in Zambia is expanding and is anticipated reach approximately 30 million people across eight countries.

Reflections

Progress has been made on CSE scale up, but **access to services** for young people remains a weak link;

While most countries have implemented some type of CSE programme, **implementation at scale** is yet to be achieved;

Programmes are doing poorly at reaching those **not enrolled in school**;

The SERAT review identified a need to determine the **quality of the new curricula and teaching materials**; and

Reaching all teachers with good quality teacher training on CSE remains a big challenge

The ESA region has a plethora of initiatives focusing on young people. The challenge is coordination at global and regional levels to ensure harmonization at country level and avoid duplication of effort. There is a need for guidance on the operationalization of the initiatives at country level, especially for All-In. The coordination role of UNAIDS could be strengthened to create convergence around “adolescents” (girls specifically) with a comprehensive focus on HIV, pregnancy, child marriage and GBV reduction as listed in Table 7 on page 28.

Table 7 Priorities for 2016-2017

KEY RESULTS FOR ADOLESCENTS AND YP	FOCUS AREAS
<ul style="list-style-type: none">• Eliminating all new HIV infections amongst adolescents and young aged 10-24 years;• Reduce early and unintended pregnancies among young people by 75%;• Eliminating GBV; and• Eliminating child marriage	<ul style="list-style-type: none">• Scaling up CSE: Good quality CSE delivered by well-trained teachers;• Linkages with adolescent/youth sensitive health services;• Support efforts to address early and unintended pregnancies and eliminate child marriage and GBV; and• Support advocacy and development and reinforcing enabling environment

More information is provided at youngpeopletoday.net

2.1.3 Sexuality Education – The Cameroon Experience

Every year 16 million adolescents give birth worldwide and nearly 3 million suffer complications from unsafe abortion. Early sexual debut is frequent among adolescents in Cameroon, which increases their chance of contracting HIV, exposure to other STIs and the likelihood of girls becoming pregnant. Early pregnancy is more frequent in impoverished, poorly educated, rural girls in the Region. Sexuality education is important to address this crucial issue as early pregnancies have serious individual and social consequences.

In Cameroon the age at first sexual intercourse amongst girls is 10-14 years and for boys is 15-18 years. Six percent of adolescents aged 10-15 years have already conceived and by the age of 15 years 8% of adolescent girls have given birth at least once. The HIV prevalence rate in young girls aged 15-19 years is 2% versus 0.4% in boys of the same age. The modern contraceptive rate in adolescent girls aged 15-19 years in union is 12.1% - 20.6% of girls aged 12-19 years are in union. The adolescent fertility rate is 127 per 1000 compared to the global average of 49. On average 25% of adolescents have begun childbearing. Of these, 14.7% do not receive antenatal care; 40.8% of pregnant adolescents give birth at home and 70% of unsafe abortions are performed on young people aged 10-24 years. (DHS-MICS 2011)

Activities carried out for adolescents in school

Education on SRH, family planning and life skills in school settings:

- Teaching materials and guides;
- Materials for teacher self-study;
- Training and coaching of teachers;
- Awareness campaign focused on ARH and voluntary HIV testing; and
- Creation of adolescent health units within health facilities for personalized counseling and provision of contraceptives free of charge to adolescents and youth

Activities carried out for out of school adolescents

Training of adolescent and youth supervisors:

- Training in adolescent sexual and reproductive health;
- Awareness campaigns focused on SRH and voluntary HIV testing using national events such as national youth day and international women's day. This year emphasis was placed on regions that are hosting refugees.

Mobile and outreach strategy:

- Counseling and provision of contraceptives

There are strong partnerships with media to conduct awareness campaigns targeting community members, parents, teachers, leaders and young people themselves.

The table below provides an analysis of the strengths weaknesses, opportunities and threats that the adolescent sexuality education programme in Cameroon faces.

Table 8 Strengths, weaknesses, opportunities and strengths

STRENGTHS	WEAKNESSES
<ul style="list-style-type: none"> • National reproductive health policy • National reproductive health programme • National orientation and implementation framework on SRH • National strategy to institutionalize the control of HIV/AIDS in the action plans of various ministries • Strengthening of school-based interventions 	<ul style="list-style-type: none"> • Lack of effective coordination and multisectoral approach • Lack of disaggregated data for adolescent and youth health • Lack of integration of SRH into the package of services offered by health care providers in health facilities and school clinics • Lack of involvement of the private education system, except the faith-based system • Low teacher interest regarding adolescent SRH
OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> • National, regional and international partnerships • Support for the creation of health clubs in schools and colleges • Existence of social marketing association and a specific programme for adolescents • Partnerships with national and local media 	<ul style="list-style-type: none"> • No formal interface for dialogue and consultation regarding adolescent SRH • Lack of reliable information on the availability and access to SRH services • No formal decree or laws making sexuality education compulsory in all schools and colleges in the country.

Conclusion and recommendations

Adolescent SRH remains a critical issue in Cameroon. Good political will exists and several adolescent health focused initiatives have been established in the country. However, much remains to be done. Key interventions in moving forward include:

- Create national and decentralized platforms for the coordination of adolescent health interventions;
- Advocate to make sexuality education compulsory in school programmes;
- Create new adolescent health units within health facilities; and
- Conduct research in the area of adolescent SRH, including family planning.



2.2 Providing adolescent friendly health services (AFHS) and increasing adolescent demand and community support for their provision

Key messages from the Journal of Adolescent Health

Effective strategies to provide ASRH services and to increase demand and community support

Evidence from research:

- A combination of training and supporting health workers, making health services friendly and outreach education contribute to increased service utilization by adolescents.
- Complementary efforts to generate adolescent demand for services and build community support for their provision, increase service utilization.
- There is limited evidence of the effectiveness of delivering health services outside of health facilities – multipurpose youth centres are not effective in increasing service utilization.
- There are no evaluations of programmes directed at vulnerable and marginalized adolescents.

Lessons from implementation experience:

- NGOs have been active in this area for a long time. Governments are increasingly taking up work in this area.
- Often there is once-off training for health workers and there is little complementary demand creation work.

Implications for action:

- Formulate and apply laws and policies to enable the provision and promotion of SRH services for adolescents.
- Implement a package of actions that include: health worker training and support; improvements to make facilities adolescent friendly; informing adolescents about available services; and building community support for their provision.

Implications for research:

- Identify effective strategies to reach vulnerable and marginalized groups of adolescents.
- Identify effective types of demand generation and community acceptance interventions.
- Carry out cost-effectiveness analyses to identify the most efficient way to expand coverage without compromising quality

2.2.1 Access to SRH including HIV services for adolescents and youth

Sylvia Wong, Technical Specialist, Adolescents and Youth UNFPA Technical Division

prepared this presentation which was delivered by **Valentina Baltag**.

Programmes that have successfully contributed to increased adolescent uptake of SRH services have included a combination of the following components: training and support of health workers; improving the adolescent-friendliness of health facilities; and information outreach for adolescents through multiple channels. These three elements need to be complemented with creating community support for the provision of health services and adolescent demand for their use. On the other hand, more evidence is required regarding outcomes among vulnerable and marginalized populations and which strategies are most effective at reaching them; which specific components in multi-component interventions are improving outcomes; and cost-effectiveness analyses to inform the most efficient use of limited resources when expanding service coverage (WHO 2015).

UNFPA has developed an Adolescents and Youth Strategy with a five-pronged approach. ASRH services is the third of these five prongs, which are:

- Enable **Evidence-Based Advocacy** for comprehensive policy and programme development, investment, and implementation;
- Promote **Comprehensive Sexuality Education**;
- Build capacity for **SRH Service Delivery** including HIV prevention, treatment and care;
- Take **Bold Initiatives** to reach marginalized and disadvantaged adolescents and youth, especially girls; and
- Promote **Youth Leadership and Participation**

UNFPA employs the following strategic actions to build capacity for SRH services: **Advocate for access to SRH services for adolescents and youth** – through various avenues including the use of disaggregated data to demonstrate the SRH situation amongst adolescents; removal of legal and policy barriers to SRH by addressing issues such as age of consent requirements and parental or spousal notification; increasing the financial commitment and resource base for ASRH; and building community support and acceptance for ASRH provision.

Improve the quality, acceptability and availability of ASRH services – this is done through strengthening quality standards and guidelines to promote and improve access as well as mainstreaming ASRH within existing health services to support sustainability.

Strengthen health providers' capacity – to provide non-discriminatory, non-judgmental and confidential services by addressing values clarification and providing ongoing supportive supervision.

Improve outreach – to services and support CSE referrals by creating linkages between health services, effective referrals through peer educators and experimenting with m-Health technology.

Support data analysis – on service coverage and utilization by identifying subgroups of adolescents being reached through existing services and realigning programmes for those most in need.

In Humanitarian Situations UNFPA applies the following strategic actions:

- Enable access by adolescents and youth to SRH services and information such as MISIP (The Minimum Initial Service Package is a series of crucial actions required to respond to reproductive health needs at the onset of every humanitarian crisis), with dedicated outreach for pregnant girls to deliver in facilities;
- Foster the participation of young people in humanitarian policy dialogue and programming, so that they are recognized as key agents in the recovery of their communities; and
- Promote a cross cutting focus on age and a life cycle approach through humanitarian, transition and recovery interventions.

Table 9 provides a list of recommendations on what to do and what not to do in programme efforts to improve ASRH services.

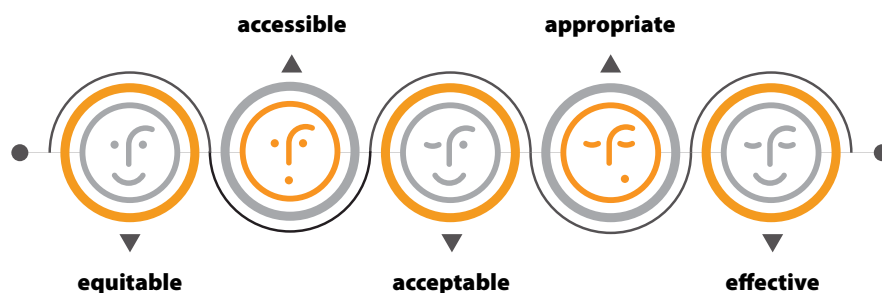
Table 9 Final Do's and Don'ts

DO	DO NOT
<ul style="list-style-type: none"> • Advocate for reliable and sustainable resources for ASRH; • Support capacity development of providers to be sensitive, non-judgmental and competent; offer supportive supervision; enact facility improvements; support community acceptance and outreach to adolescents and youth; • Invest in operations research to provide a stronger evidence base on how to best deliver and improve ASRH access, and for whom; and • Stratify results along adolescent and youth diversity to identify effective strategies to reach those most in need 	<ul style="list-style-type: none"> • Support boutique, standalone projects as these are rarely sustainable; • Support popular interventions that don't lead to positive SRH outcomes e.g. multi-purpose youth centres to provide SRH services; and • Expect results without explicit efforts to identify and reach vulnerable adolescents over time.

A useful list of resources is provided in Annexure 1.



Characteristics of Adolescent friendly services



2.2.2 Pathfinder: Adolescent-Friendly Health Services

This presentation, prepared by **Gwyn Hainsworth. Pathfinder** and delivered by **Valentina Baltag**, highlighted the characteristics of adolescent friendly services and what is required for effective scale up of these services.

WHO defines adolescent-friendly services as **equitable** – all adolescents, not just certain groups, are able to obtain the services they need; **accessible** – adolescents are able to obtain the services that are provided; **acceptable** – services are provided in a way that meets the expectations of young clients; **appropriate** – services respond to the needs of adolescents; and **effective** – the right health services are provided in the right way and make a positive contribution to adolescents' health.

AFHS were introduced in the mid 1990s in low and middle-income countries (LMIC). Pathfinder has supported these efforts in Sub-Saharan Africa (SSA) in countries like Tanzania, Ghana, Botswana, Uganda, Mozambique, Nigeria, Ethiopia, Kenya, and more recently in South Africa. These experiences and the evidence generated from various AFHS initiatives have generated key lessons on important elements, which are vital to the success of adolescent friendly services:

Package of SRH services offered by providers trained in AFHS – As adolescents are less likely to go to health facilities than adults, it is important to offer an integrated package of services to avoid any missed opportunity to address their SRH needs.

Emphasis on privacy, confidentiality, respectful treatment, and free or

subsidized services – A review of the research on adolescent preferences show that adolescents consistently prioritize privacy, confidentiality, and respectful treatment by providers as the most important attributes of AFHS. A recently published review of AFHS scale up experience in five countries noted that despite some differences in how AFHS was implemented, all five countries ensured privacy and confidentiality, had trained providers who offered respectful care to clients, and offered free or subsidized services (Hainsworth 2014).

Should be accompanied by demand generation and activities to create an enabling environment – In addition, all five countries that scaled-up YFS also had strong demand generation and enabling environment components, including efforts to address gender norms and stigma that prevent adolescents (especially girls) from seeking SRH services. Four of the countries used peer educators as well as community mobilization interventions to create support for young people to seek services, while one country used social marketing and mass media.

Emphasise youth participation and leadership in programme design and implementation – In addition, each programme emphasized youth participation and leadership in the programme design and implementation

Although there are many channels and modalities through which AFHS can be provided, the translation of these characteristics or principles of quality services for adolescents is not always effective at the country level. AFHS are offered at integrated youth centers in many

countries despite a systematic review that shows that youth centers are not cost effective in terms of increasing adolescent uptake and use of services (Zuurmond 2012). In many other countries AFHS is implemented as a separate space model (separate AFHS room within a health facility) as a way of responding to young people's desire for increased privacy and confidentiality. However, this model may not always be the most appropriate in the context of the local health system and can be more costly. Although this separate space model has been scaled up in some countries, there are other countries that have either not been able to scale it up or sustain it once it has been scaled up due to resource limitations (both human and financial resources).

There is growing recognition, most notably in the WHO's 2014 report, Health for the world's adolescents, that to achieve universal coverage for young people, we need to shift from small-scale AFHS initiatives to adolescent-responsive health systems. This requires a shift in the way AFHS are conceptualized and designed, away from a one-size-fits-all model to an adapted and contextualized model of AFHS that is appropriate to the systems of a country and the needs of its diverse adolescent population and that can be sustainably scaled up.

Key take-away messages around AFHS scale-up

- Simultaneously pursuing expansion and institutionalization increases sustainable scale up of AFHS
- A supportive policy environment for institutionalization provided the necessary mandate for expansion of AFHS
- Expansion of AFHS led to greater service utilization and generated community awareness and engagement, thus holding governments accountable for operationalizing adolescent health policies
- Institutionalization of AFHS tools and curricula resulted in efficient expansion
- Young people's lack of political voice requires greater advocacy to ensure expansion and institutionalization of AFHS
- Need to partner with health systems strengthening (HSS) efforts to ensure an age-disaggregated health management information system (HMIS) and that AFHS are included in national supervision and quality improvement systems
- Capacity building of MOH and NGO staff is critical for expansion and institutionalization of AFHS, including incorporation of AFHS within country budgets and work-plans, which is essential for long term sustainability

2.2.3 Tools to support the implementation of ASRHR recommendations

Valentina Baltag, WHO/HQ presented a set of tools developed by WHO to assist with implementing a package of actions which include:

- Health worker training and support;
- Improvements to make facilities adolescent friendly (AF);
- Informing adolescents about available services; and
- Building community support for their provision.

The **Global Standards for Quality Health Care Services for Adolescents** is a tool that will support the implementation of the

following eight standards statements:

- **Adolescents' health literacy** – the health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
- **Community support** – the health facility implements systems to ensure that parents, guardians and other community members and community organisations recognize the value of providing health services to adolescents and support such provision and the utilization of such services by adolescents.
- **Appropriate package of services** – the health facility provides a package of information, counseling, diagnostic, treatment and care services that fulfills the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.
- **Providers' competencies** – health care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health care providers and support staff respect, protect and fulfill adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude and respect.
- **Facility characteristics** – the health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
- **Equity and nondiscrimination** – the health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
- **Data and quality improvement** – the health facility collects, analyses and uses data on services utilization and quality of care, disaggregated by age and sex to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
- **Adolescents' participation** – adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

The second tool is entitled **Core**

Competencies in Adolescent Health and Development for Primary Care Providers

and aims to provide a framework of core competencies in adolescent health and development for primary care providers. The tool has global relevance and can be used to assess the adolescent health component in the pre-service curriculum.

There is a two-fold rationale for articulating core competencies. Firstly primary care providers express the need to access training on adolescent health and development yet in many countries such training is not available or accessible. Secondly, having competencies in paediatric or adult care is not enough because adolescents are not simply 'older children' or 'younger adults'; individual, community, organizational and structural factors make adolescent clients unique in the way they understand information, what information and which channels of information influence their behaviours, and how they think about the future and make decisions in the present.

The tool is separated into three domains. Domain 1 deals with basic concepts in adolescent health and development, and effective communication; Domain 2 addresses law, policies and quality standards for the foundation of adolescent health care; while Domain 3 comprises the clinical care of adolescents with specific conditions. These three domains are further broken down into 17 competencies as tabulated in the Table 10 on page 33.



Table 10 ASRH domains and competencies for HCP

DOMAIN	COMPETENCIES
1 Basic concepts in adolescent health and development, and effective communication	1.1 Understand normal adolescent development, its impact on health and its implication for health care and health promotion 1.2 Effectively interact with an adolescent client
2 Laws, policies and quality standards	2.2 Apply in clinical practice the laws and policies that affect adolescent health care provision 3.3 Deliver services for adolescents in line with quality standards
3 Clinical care of adolescents with specific conditions	3.1 Normal growth and pubertal development 3.2 Provide immunisations 3.3 Manage common health conditions 3.4 Mental health 3.5 SRH 3.6 HIV 3.7 Promote physical activity 3.8 Nutrition 3.9 Chronic health conditions 3.10 Substance use 3.11 Violence 3.12 Unintended injuries 3.13 Endemic diseases

Key message:

EVERY primary care provider i.e. nurses, CHWs, general practitioners, family physicians, paediatricians etc. should have core competencies in adolescent health and development

A list of resource materials and a tool to support the implementation of the **Global standards for quality health care services for adolescents** are listed in Annexure 1 of this report.

2.2.4 Providing AFRHS, increasing adolescent demand and community support: the Tanzanian experience

Dr Elizabeth Mapella, National Coordinator of the Adolescent Reproductive Health Programme in the Ministry of Health and Social Welfare, presented the country experience on behalf of the United Republic of Tanzania.

As the national coordinator for adolescent reproductive health (ARH) Dr Mapella's responsibility is to use research to develop national policies, strategies, standards etc. to improve the SRH of adolescents and young people in the country. Young people aged 10-24 years constitute 31% of Tanzania's total population of 45 million people. The country contraceptive prevalence rate for modern methods is 27% and among youth is only 12% (TDHS 2010). Overall, 23% of young women are mothers or have given birth and 30% of young women have experienced physical violence since the age of 15 years. Youth account for 60% of the new HIV infections (THMIS 2012). Provision of AFRHS is below the national target of 80%.

The Reproductive and Child Health Section of the Ministry of Health led the process for development of the National Adolescent Health and Development Strategy (2004-2008, 2011-2015). The promotion of ASRH is a key focus of the strategy. The national strategy has the following strategic objectives:

1. Strengthened policy and legal environment to support provision of SRH information, services and life skills for adolescents;
2. Increased adolescents' access to and utilization of quality RH services;
3. Positive attitudes and behaviours promoted among parents, adolescents and the community towards improvement of ASRH; and
4. Strengthened capacity of key stakeholders to deliver effective and efficient ASRH programmes.

The MOH has put in place a national standards-driven quality improvement initiative to improve the quality and expand the coverage of an evidence-based package of health interventions in order to achieve clearly defined health outcomes. The standards provide the benchmark for assessing, guiding and providing AFSRH services.

There are seven standards statements:

- 1 Information and advice;
- 2 SRH services;
- 3 Information on ARH rights;
- 4 Provider competence;
- 5 Policies and management systems;
- 6 Organization of service delivery points (SDPs); and
- 7 Community and Parental Support.

Each specifies the required performance level at service delivery points in terms of both health worker as well as health system performance and is accompanied by a clear listing of what needs to be done to achieve the standards and how to verify that work is proceeding as planned.

The steps that Tanzania has taken, at national, regional and district levels, to translate strategy into action were recently published in BMC Public Health and are summarized in the bullet points below (Chandra-Mouli 2013). WHO provided

invaluable support throughout this process.

National level actions

- Mapping what was being done in country by different players.
- Developing national quality standards and guidelines in a consultative manner with a wide range of stakeholders, including adolescents and young people.
- Defining actions needed - at the national, regional, council and local levels - to achieve the quality standards.
- Adapting generic implementation and monitoring tools e.g. WHO, FHI Standards.
- Building capacity of a group of national facilitators to use the tools and support others to use them.
- Advocating for the integration of AFRHS activities into relevant national programmes. For example, including training modules on ASRH in the ongoing work of the HIV/AIDS programme and pre-service training and disaggregation of HMIS data to include adolescents and youth.
- Allocating and mobilizing government resources - medium term expenditure framework (MTEF) and Comprehensive Council Health Plan (CCHP) - and support from external sources e.g. Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

Regional and District level actions

- Informing and engaging Regional/District Health Management Teams (RHMT/DHMT) around the country to explain the national quality standards to regional medical officers and encourage them to include activities to implement and monitor them in their work plans and budgets.
- Supporting the application of the quality standards by all players - working with national partners to support RHMTs in applying the quality standards and encouraging other partners e.g. international NGOs such as FHI 360 and

national ones such as AMREF, to apply them.

More than 85% dissemination coverage has been achieved of the National Standards documents to policy and decision makers at Regional and District levels. Budget lines for ASRH have been integrated into the medium term expenditure framework (MTEF), Council Plans and assistance support from development partners. Human capacity has increased 85% in terms of staff numbers and health workers have been trained on AFSRH services through in-service and pre-service training.

Young people are increasingly aware of the services and are actively participating in issues of SRHR. There is increasing coverage of SDPs that provide AFSRH services and increasing utilization of SRH services by adolescents and youth. The national HMIS tools have been disaggregated by age and sex providing improved reporting on ASRH service utilization.

2.2.5 Pregnancy control strategies among adolescents enrolled in school in Cote d'Ivoire

This presentation, delivered by *Dr Marie Paula Ourega Loba, Director of the National Program of School and University Health*, provides perspectives on the Zero Pregnancy in Schools Project.

Cote d'Ivoire is home to 23 million inhabitants. Thirty four percent of the total population falls within the 10-24 year old age range. Over the years there is a decreasing trend of pregnancies in adolescent girls enrolled in school.



Table 11 below shows the epidemiological data pertaining to the sexual and reproductive health of adolescents and youth in Cote d'Ivoire extracted from the routine data system.

Table 11 Epidemiological data on SRH in adolescents and youth in Cote d'Ivoire

INDICATOR	VALUE
National HIV prevalence	3.7%
HIV prevalence in 15-24 year olds	1.3%
HIV prevalence in 15-24 year old females	2.2%
HIV prevalence in 15-24 year old males	0.3%
STI prevalence in 15-24 year old females	9.3%
STI prevalence in 15-24 year old males	6.5%
National contraception rate	13%
Contraception rate in 15-24 year olds	7%
Unsafe abortion rate in 15-24 year olds	42.7%
Teachers admitting sexual intercourse with students	47.6%

Source: DHIS III 2011-2012

Schoolgirl pregnancy

The table below lists the number and percentage of schoolgirl pregnancies in Cote d'Ivoire at primary and secondary school. It shows that at the primary level, teenage pregnancies start in grade 4 students and the highest pregnancy rate is observed in grade 6 with 80% (2013) and 63% (2014) of the primary school pregnancies respectively. Of primary school pregnancies, 71% were registered in rural areas and 29% in urban areas.

Table 12 Number of schoolgirl pregnancies in Cote d'Ivoire (2013-2014)

EDUCATION LEVEL		NUMBER OF PREGNANCIES					
		2013		2014		Difference	
		No.	%	No.	%	No.	%
Primary school	Grade 4	49	4.3	47	16.5	2	4.1
	Grade 5	172	15.1	58	20.4	114	66.3
	Grade 6	916	80.6	179	63	737	80.4
	National	1137	100	284	100	853	75
Secondary school	Form 1	530	13.5	547	14.3	-17	-22
	Form 2	588	14.9	569	14.9	19	3.2
	Form 3	733	19.6	569	14.9	164	22.4
	Form 4	912	23.2	905	23.7	7	.77
	Form 5	270	6.9	218	5.7	52	19.3
	Form 6	337	8.6	297	7.8	40	11.9
	Form 7	529	13.4	470	12.3	59	11.1
	National	3939	100	3820	100	119	3
Total National	5076		4104		972	19.1	

Source: MENET-MSLS-PNSSU

The number of primary schoolgirl pregnancies decreased dramatically by 75% (from 1137 pregnancies in 2013 to 284 pregnancies in 2014) and by 3% among secondary schoolgirls (from 3939 pregnancies in 2013 to 3820 in 2014). The total number of pregnancies reported nationally decreased by 972 (19.1%) from 5076 in 2013 to 4104 in 2014. This result was achieved through the combined effort of the Ministry of Health and HIV/AIDS Control and the Ministry of General and Technical Education, which led the engagement between government and partners.

Strategy to control teenage pregnancy in schoolgirls

Cote d'Ivoire introduced a teenage pregnancy control strategy through a project called Zero Pregnancy in Schools - an accelerated plan to reduce pregnancies in schools (2013-2015). It is a multisectoral response involving all stakeholders working on adolescent health and development and consists of three key components:

- Education and health promotion with awareness raising and training on sexuality education in schools;
- Capacity strengthening and service provision at health centres, including provision of contraceptives to adolescents; and
- Emphasis is given to the legal sector in order to pass and enforce laws that punish teachers and other adults who have sex with students or young girls.

The general objective of the project is to reduce the number of teenage pregnancies in schools through an accelerated plan covering the 3-year period 2013-2015. It has three specific objectives:

- 1 To create a national awareness and mobilization;
- 2 To reduce the number of teenage pregnancies in schools significantly; and
- 3 To give girls a quality education by ensuring their retention in school.

Project Zero Pregnancy in Schools is implemented using the following six strategies:

- Create an enabling environment for administrative, social, media and legal activities;
- Carry out information, education and communication activities pertaining to sexual and reproductive health with students themselves as key agents for change;
- Use of arts, culture and sports for the promotion of sexuality education in school;
- Use of new technologies, social media in promoting the provision of sexual and reproductive services to young people;
- Strengthen sexual and reproductive health services in school settings; and
- Reducing the vulnerability of girls enrolled in school.

Political commitment

The First Lady of Cote d'Ivoire (Ms Dominique Ouattara), the Minister of Health and HIV/AIDS Control (Dr Raymonde Coffie Goudou) and the Minister of General and Technical Education (Ms Kandia Camara) led advocacy at all levels on the teenage pregnancy issue in Cote d'Ivoire.

Government also gave more consideration to teenage pregnancy and took action to better address it. Development partners and NGOs committed to provide technical and financial support to Government.

Sensitisation and training of young people and health care providers

Activities to sensitise and train young people, teachers and health care providers included:

- Integrated campaigns targeting students and young people to raise awareness of teenage pregnancy during cultural events;
- Inclusion of sexuality education in schools using educational worksheets developed and tailored for all levels; and
- Capacity strengthening targeting teachers as well as health care providers.

Intensification of the provision of SRH services to adolescents and youth, including contraception

Activities to improve SRH service provision included the following:

- Strengthening the capacity of health workers to provide various contraceptive methods;
- Provision of free reproductive health commodities to adolescents and youth through UNFPA support; and
- Information, education and communication campaigns focusing on SRH, including family planning.

As a result of intensified campaign activities the prescription of contraceptives has increased by five times in certain localities where the utilization rate was lowest.

Table 13 Contraceptive use during the campaign and 6 months later (2014-2015)

LOCALITY	TYPE OF CONTRACEPTIVE									
	ORAL		INJECTABLE		IMPLANT		CONDOMS		FEMIDOMS	
	Cam.	Post	Cam.	Post	Cam.	Post	Cam.	Post	Cam.	Post
<i>Korhogo</i>	64	240	39	225	35	136	1578	596	50	154
<i>Sakassou</i>	20	105	15	386	11	168	549	217	53	25
<i>Treichville</i>	9	17	0	4	0	1	746	985	50	52
<i>Bondoukou</i>	80	132	33	244	39	164	1500	4860	50	400
TOTAL	173	512	129	859	85	469	4373	6658	203	631

Source: MSLS-PNSSU

National commitments around adolescent health

School and university health programme since 2001;

- Establishment of 163 school and university health services, 120 school clinics and school health clubs;
- Development of several national strategic plans focused on school and university health (2001-2005, 2006-2010 and 2010-2014), but these were not funded;
- Development of national adolescent and youth health programme (2016-2020) taking into account health issues affecting school and out of school adolescents and youth;
- Consideration of indicators for adolescents and youth health in the HMIS and collection of disaggregated data by age and sex;
- Establishment of a consultation platform with other sectors and stakeholders;
- Commitment of the Societe Ivoirienne de Pediatrie (SIP) in the mother and child programme and now adolescent health;
- Development of national standards for adolescent and youth friendly health services;
- Adaptation and adoption of training modules focused on adolescent and youth health;
- Training on adolescent and youth health targeting health care providers working at the school and university health centres with the support of WHO, UNICEF and UNFPA (Muskoka and H4+ initiatives);
- Development and implementation of an accelerated plan to control and reduce the number of teenage pregnancies in school;
- Acceleration of the provision of SRH services, including FP and training of health care providers on the prevention and management of STIs and HIV/AIDS within school and university health centres; and
- Launching of ALL-In initiative to end AIDS among adolescents.

Challenges and recommendations

- Recognition of adolescence as a specific target group;
- Strengthening capacity in school and university health centres and integration of adolescent and youth health in referral facilities;
- National ownership in relation to the distribution of contraceptives to adolescents;
- Scale up of the implementation of adolescent health interventions through training and improved provision of sexual and reproductive health services to adolescents and youth;
- Financing for adolescents and youth programmes;
- Improving the monitoring and evaluation of adolescent health interventions; and
- Operational research.

2.2.6 The Commercial Approach to Creating Demand & Behavioural Change: a formula for success in Africa
Temitayo Erogbodgo gave this presentation that explains the basis of the commercial approach to demand creation and behaviour change communication.

The commercial sector has developed tried and tested approaches and a methodology that **creates new demand for retail products and services, alters consumer-purchasing behaviour, creates new markets** and has been the driver for trillions of dollars in sales and services.

Multinational corporations engage commercial communications agencies to provide the best-in-class communications, conduct market research, develop creative communication strategies and measure their impact.

Commercial communication agencies use a tested methodology. In order to survive in a highly competitive space, these agencies continue to evolve, innovate, and harness new technologies and communications tools. They undertake formative research to uncover the motivations, aspirations and fears of the consumer and use these findings to develop creative, meaningful and engaging communications that speaks to that individual, e.g. the proprietary process that McCann calls “Truth 2 Transformation” (<http://www.maclarencultura.com>). They measure what works, adjust strategies

accordingly, and strive for cost effectiveness and return on investment.

He left delegates to answer this provocative question: **“How and why do you know about these brands AND have opinions about them?”**

2.3 Adolescent and youth participation and leadership

Key messages from the Journal of Adolescent Health

Key strategies to increase adolescent and youth participation and leadership in health programmes

Evidence from research:

A number of frameworks have been developed to better define, implement and monitor youth participation.

There is little evaluation and research on the effectiveness of youth participation and leadership efforts. The one exception is peer education – the available evidence suggests that it is not effective in bringing about behaviour change.

Lessons from implementation experience:

There is increasing youth participation in global processes.

There is structured participation in some organizations such as IPPF.

At the country level, there is more youth participation than before; but it can be token participation.

Implications for action & research:

Combine efforts to pursue meaningful youth participation with efforts to assess whether they contribute to the success of programmes and projects.

Participation is a right and therefore, should not be evaluated only in terms of whether or not it improves health programmes and health outcomes.



2.3.1 Adolescent participation

This presentation by **Valentina Baltag from WHO's Department of Maternal, Newborn, Child and Adolescent Health** provided an overview on the types and levels of youth participation.

Young people participate in programmes and policies for a variety of reasons. It may be a means or an end in itself. Participation is also an obligation - a legal obligation in terms of the Convention on the Rights of the Child (CRC) and it is a moral obligation for the social and political good for all (IPPF 2012).

Levels or elements of participation vary along a continuum as illustrated in the figure below. Any combination of these elements can be used effectively, depending on the type of decision being made and the level of innovation utilized.

Figure 9 below represents the forms of social participation in health care, which range from informing people with balanced objective information, at one end of the spectrum, to empowerment by ensuring that communities retain ultimate control over the key decisions that affect their wellbeing at the other (WHO 2008).

Figure 9 Levels of participation

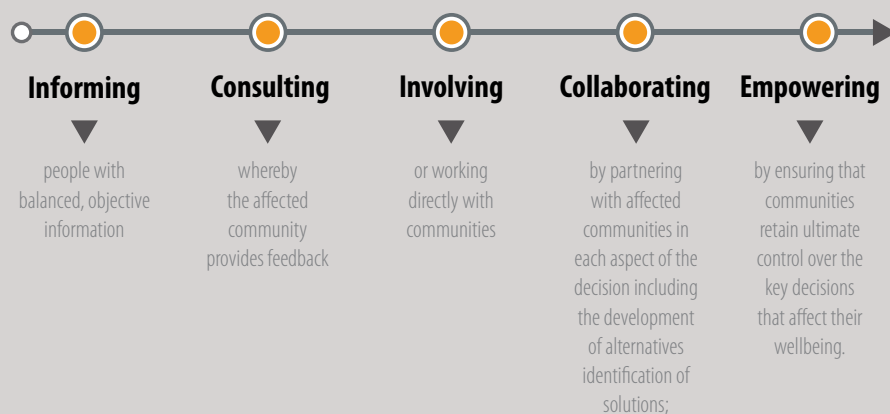
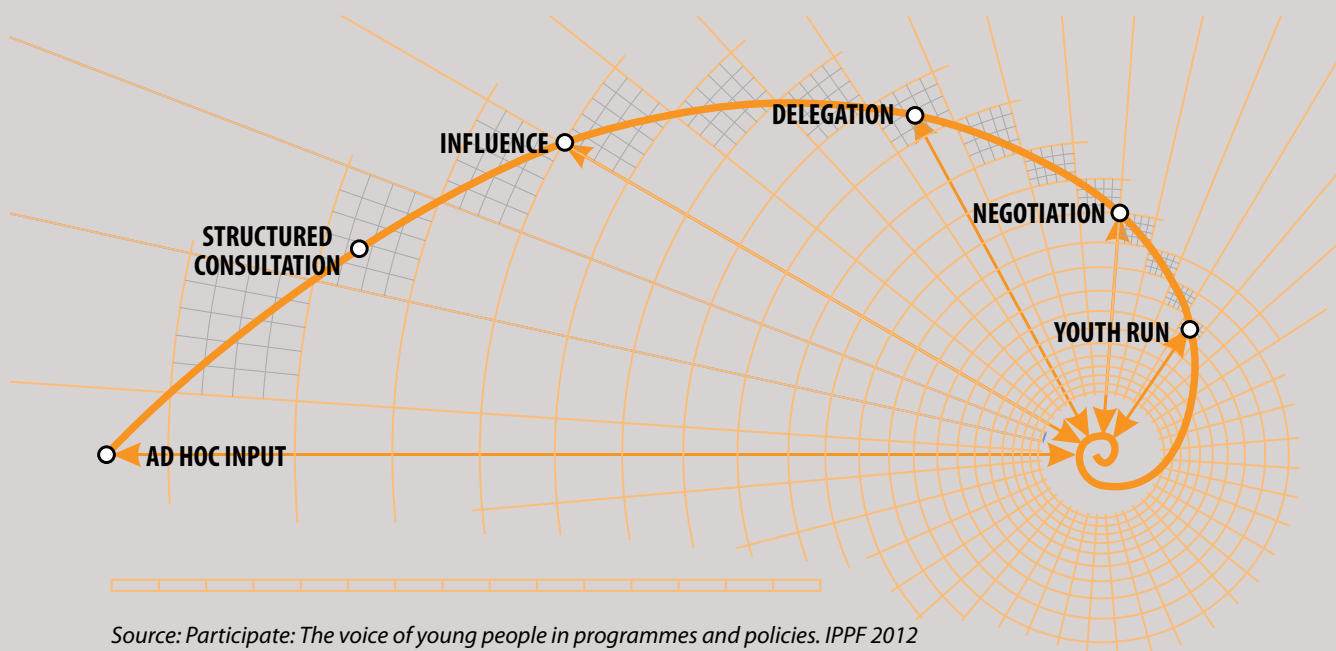


Figure 8 Defining participation



Barriers to youth participation include personal barriers, structural or institutional barriers as well as cultural and social barriers. Standards must be created to establish practical mechanisms for participation. Standard 8 in the WHO Global standards for quality health care services for adolescents states that: ***“Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care as well as in certain appropriate aspects of service provision.”*** The document promotes competencies in respecting adolescent clients’ choices; valuing and engaging in partnerships with adolescents; and regularly assessing the quality of health service provision, including assessments of adolescents’ experience of care, and application of findings to improve quality of care.

Common features of adolescent participation

- Participation must be voluntary.
- Participation should be a primary consideration, and not merely an afterthought.
- Participation varies according to each adolescent’s evolving capacity.
- All children and young people can participate in different ways from a young age.
- Participation makes sense for adolescents if they are able to engage in and influence areas that are meaningful to them.
- Resistance can be an important form of participation.
- Adolescent participation challenges the status quo but does not negate the vital role of adults.
- As crucial as it is, participation is not a panacea – it does not solve everything.



Research has found little effect of adolescents' participation in programming for health (Cook 2008).

Dr Baltag provided an example of successful advocacy conducted by Health Related Information Dissemination Amongst Youth (HRIDAY), a voluntary organization of health professionals and social scientists engaged in activities aiming to promote health awareness and informed health activism among school and college students in India. HRIDAY partners with the Student Health Action Network (SHAN). Since 1998 HRIDAY-SHAN has led advocacy for limits on tobacco advertising in India and has since moved from advocacy to monitoring compliance with regulations.

2.3.2 Youth participation in the International Planned Parenthood Federation (IPPF)

This presentation was prepared by **Doortje Braeken, Senior Advisor Adolescents Gender and Rights, IPPF, London** and presented by **Valentina Baltag**.

The IPPF's vision of youth participation has changed and evolved over time from notions of **Youth involvement** – getting voices heard and a focus on democracy; to **Youth-adult partnership** – youth participation as an institutional part of the system or organization; to an **Emancipatory approach** to youth participation with a focus on empowerment and active citizenship; and finally to a **Youth-centred approach** where all young people, be they clients, volunteers, board members etc. are partners for social change.

The IPPF youth participation journey involved a number of steps as listed below and a process of learning from the organisation's strengths:

- **Literature review** – The literature review focussed on IPPF's programme evaluations, evaluations of other youth programmes (UNFPA, ActionAID, Amnesty International, Save the Children), organisational youth strategies, and youth participation guides and best practice documents.

- **Targeted Interviews** – with experts internal and external to the IPPF
- **Survey of current and former young staff and volunteers** – The interviews included the secretariat youth team and other teams, current and former youth leaders from both within and outside IPPF, other youth-focussed organisations and networks, using a series of interview questions developed ahead of time.
- **Feedback from youth secretariat**

Figure 11 IPPF's journey of youth participation



• **Evolutionary process**

IPPF's vision for the next step in youth participation is a youth centred approach where participation is emancipatory and about empowerment. Besides being a right, participation is a method that strives to ensure that policies and interventions meet the real needs, rights and aspirations of the people involved.

Participation of young people can bring cultures together around issues of the rights and welfare of young people rather than endorsing a single model of how policies should work. Participation practices allow a focus on people's felt needs overcoming some of the assumptions and biases of development professionals, projects and programmes.

Participation can empower people by giving them a voice and responsibility. In the process of youth participation, young people involved can benefit from the position they get, by the training and support they receive and the support and feedback on their decisions and activities. Youth participation offers them the opportunity to learn collaborative and problem-solving skills, to express their needs and concerns, to become aware of differences in attitudes and lifestyles and to promote acceptance and respect.

Empowerment is not simply about giving young people opportunities to access services and make choices about their health care, it is what else they get from it. It is a transformation in young people's understanding of their rights and feeling confident in the development of their identities. Decision makers, practitioners and service providers working to serve young people should re-imagine empowerment as a journey in which the range of possibilities that an individual perceives for their life, in which they develop the capacity to see themselves as the central actor in their lives, making choices and taking actions to achieve their aims and desires, in which they feel they can have a positive impact on the lives of people around them, and advocate for those whose sexual rights are ignored.

A youth-centred approach has the following characteristics:

- Systematic approach to involve young people at all levels
- Shifting our thinking from 'working for' to 'working with'
- No longer a distinction between young people as clients or as volunteers; all are partners for social change
- Young people (equitably female and male and representing the marginalised) hold decision-making positions in the organisation.
- Youth issues are integrated into the organisation's business model, which includes social objectives such as empowerment etc.
- All staff are trained and have youth-friendly and non-discriminatory attitudes.

It is clear that over the last 25 years IPPF has helped to transform many young people's lives and contributed to their overall development. In order for IPPF to continue to build on this legacy and support young people to become leaders of social change we should consider working towards a Youth Centred Approach. It requires commitment to meaningful internal review and long-term organisational change to achieve this. IPPF, in consultation with the Regions, has identified five principles that underpin their youth centred approach, and a series of recommendations on how this work can be furthered.

Five key lessons for participation:

- 1 Strong institutional commitment to young people as equal partners;
- 2 Recognition of the diversity amongst young people;
- 3 The creation of participatory spaces and opportunities;
- 4 Financial commitment and sustainability; and
- 5 Active support to create an enabling social and legal environment

To measure the success and impact of participation on young people e.g. improved confidence, ASRHR, citizenship, democracy, and within the organization e.g. changes in attitudes of management and providers, there is a need for stronger qualitative indicators that measure experiences, perceptions and level of satisfaction. We should move away from just measuring numbers of services towards measuring impact i.e. not make a linear indicator of participation and uptake of services, decrease of pregnancy etc.

Selected resources for participation are available list on the Resources list in Annexure 1 at the end of this report.

2.3.3 Zimbabwe's experiences in supporting adolescent participation and leadership

Mr A Mangombe (MoHCC) and **Dr T Kanyowa (WHO)** delivered this presentation on the Zimbabwean experience of supporting adolescent participation and leadership.

The presentation began by setting the context of the operating environment for adolescent participation and leadership with the following key points:

- Zimbabwe's Constitution and Youth Policy recognize the establishment of a Junior parliament;
- Zimbabwe promotes people's participation as a right enshrined in the Convention on the Rights and Welfare of Children, article 12: "**right to be listened to and to be taken seriously**";
- One of the six guiding principles of the National ASRH Strategy 2010 – 2015: "**Meaningfully involve young people, parents/guardians, schools and community in ASRH programming**";
- The Strategy (**activities 4c, 4d and 4e**) proposes: **the need for establishment of structures and networks for young people's participation; conducting a capacity building needs assessment and implement the results (capacity building plan).**

Current systems and structures include: (1) The Junior Parliament, which works with the youth health cluster under the auspices of the Zimbabwe Youth Council. It has Ministers, senators, members of parliament (MPs), as well as councilors for health matters and periodically updates the Minister and Parliamentary Portfolio Committee on Health and Child Care; and (2) The National Young People's network on SRH and HIV, which is a registered youth association that is decentralized to the district level.

Zimbabwe has accomplished a number of achievements in advancing youth participation and leadership. These include:

- A national capacity assessment for both the junior parliament and young people's network on SRH & HIV;
- Ongoing capacity building of the junior parliament and the network, especially in the areas of value based leadership skills, meaningful participation of young people, advocacy and social research;
- The National AIDS Council board has a slot for a youth person (YP) below 25 years;
- The Ambassador for the Safeguard Young People regional campaign is a survivor of early marriage. The theme song for the campaign was composed and sung by young people;
- The young people's network is the country's AFRIYAN chapter;
- Young people are also members of community based ASRH Committees;
- Junior parliament and young people's network are full members of the National ASRH Coordination Forum (including the executive), the National Technical working group on young people & HIV and currently the Steering Committee on Review on ASRH interventions and national adolescent fertility study;
- Young people are also recruited as peer educators or counselors in communities, health facilities and schools;
- The network has participated in both regional and international campaigns on SRH, e.g. the regional Y4CARMMA campaign and the AU ending Child Marriage campaign; and
- Young people (through the network

and the junior parliament) are the administrators of the ASRH & HIV facebook page: <https://www.facebook.com/YoungPeoplesNetworkGetEngaged>



Success Story

A female adolescent (Tinasha), started as a junior member of parliament, nominated to be first secretary for the YPSRHH in 2010, became one of the five member team for writing the National ASRH Strategy:2010-2015. She then became the first ever young person to sit in the NAC board. She was then engaged by UNAIDS as a focal person for youth and HIV until 2014 when she left for the African Union department for Social Affairs to date. She graduated with a BSc Honours in Sociology and Gender Studies at a local university

However, there are still gaps as the participation of young girls and women is still very low and there are no universally defined indicators for measuring adolescent and youth participation.

Opportunities for strengthening youth participation lie in pursuing avenues such as:

- The rolling out of the new and social media platforms, such as the U-Report (<https://www.facebook.com/pages/U-report-Zimbabwe/1477396805878097> and <https://zimbabwe.ureport.in/poll/28/>);
- The participation of young people in the current review of ASRH interventions through activities such as planning committees, data collection and validation; and development of the National ASRH Strategy II; and
- The development of a web-based database on youth SRH service organisations to improve networking and collaboration between service providers and young people

2.4 Addressing intimate partner and sexual violence amongst adolescents

Key messages from the Journal of Adolescent Health Supplement

Addressing intimate partner & sexual violence among adolescents: Emerging evidence of effectiveness

Evidence from research:

Parental support interventions prevent child maltreatment

Psychological support interventions aimed at children and adolescents exposed to violence reduce perpetration of violence

School-based dating violence prevention interventions reduce violence perpetration

Community-based participatory group education improves gender-equitable attitudes but has not been shown to change behaviour

Lessons from implementation experience:

Most efforts in low and middle-income countries are small-scale and time-limited projects

Implications for action:

Formulate and apply laws that promote gender equality

Implement interventions that challenge social norms that condone gender-based violence

Adapt and test interventions that have been successfully applied in high-income countries

Implications for research:

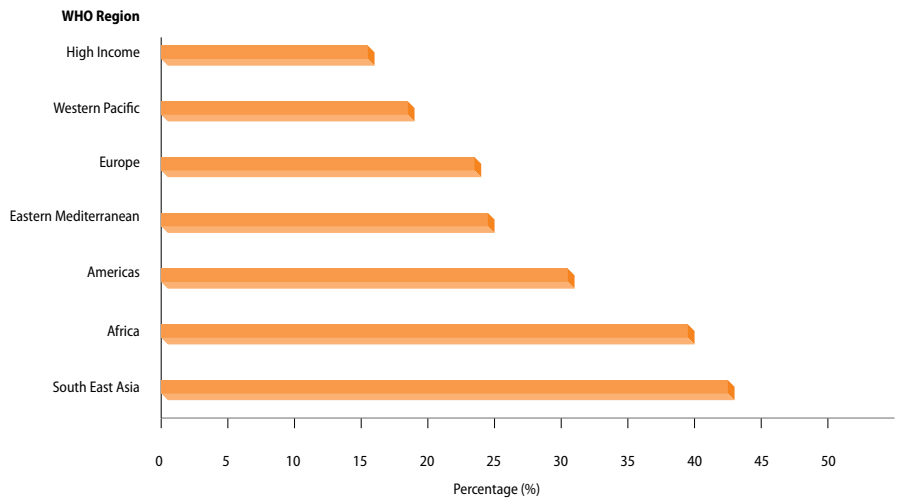
- Carry out longitudinal research to identify pathways to violence
- Conduct longer-term follow up on perpetration/experience of violence, to assess the sustainability of behaviour change
- Carry out research to find out what works to prevent violence against special groups e.g. migrants, domestic workers

**2.4.1 Addressing intimate partner violence and sexual violence against adolescents:
What works?**

This presentation given by **Dr Avni Amin from the Department of Reproductive Health and Research, WHO HQ** provided an overview of strategies and interventions that work in terms of combatting intimate partner and sexual violence among adolescents.

On average 30% of females across the world have experienced physical and/or sexual violence at the hands of an intimate partner. The figure below shows the rates of intimate partner violence among ever-partnered girls aged 15-19 years organized by WHO Region. Africa, with a rate of 40% ranks second to South East Asia, which has a strikingly high IPV prevalence rate of between 40 and 45%!!

Figure 12 Lifetime prevalence rates of intimate partner violence among ever-partnered girls aged 15-19 years, by Region



The lifetime prevalence rate of childhood (<18 years) sexual abuse is higher for girls (19%) than among boys (6%) (Stoltenborgh 2011). A WHO multi-country study on prevalence of sexual abuse of girls before the age of 15 years collected data from three African countries – Ethiopia, Namibia and Tanzania. The table below indicates the childhood sexual abuse figures reported by women who participated in this study on women’s health and domestic violence (Garcia-Moreno 2005).

Table 14 Percentage of women reporting sexual abuse by site

SITE	FACE TO FACE REPORT			ANONYMOUS REPORT			BEST ESTIMATE
	N	%	Total # of respondents	N	%	Total # of completed cards	
Ethiopia province	7	0.2	3 014	211	7	3 014	7.0
Namibia city	73	4.9	1 492	318	21.3	1 492	21.3
United Republic of Tanzania city	79	4.4	1 816	195	10.7	1 816	12.2
United Republic of Tanzania province	60	4.2	1 443	124	8.5	1 451	9.5

Source: Garcia-Moreno C et al. 2005.

A review of 61 interventions to prevent intimate partner violence and sexual violence against adolescents classified these according to four levels of effectiveness (1 = Effective, 2 = Promising or Emerging, 3 = Unclear and 4 = Ineffective) based on the criteria described in the next paragraph. Types of intervention included: Parenting (n=8), Targeted interventions for children and adolescents exposed to violence (n=3), School-based interventions (n=32), Community-based including social norms marketing (n=16), and Economic empowerment (n=2). Seventeen of these interventions were implemented in LMIC. Eight programmes targeted adolescents younger than 15 years of age. Programmes were categorized into one of four categories - effective, emerging or promising, ineffective or unclear - according to the following criteria:

Effective: Programmes supported by multiple well-designed studies showing prevention of perpetration and/or experience of intimate partner and/or sexual violence. In order to be considered effective, programmes had to demonstrate change in the experience or perpetration of violence, not only improved knowledge and/or attitudes. This category also includes programmes that have been replicated beyond the initial pilot.

Emerging evidence of effectiveness: Programs evaluated by well-designed studies showing positive changes in knowledge, attitudes and beliefs related to intimate partner violence and/or sexual violence. Violence perpetration or experience not measured. There has been little or no replication and unclear relevance to developing country settings.

Ineffective: Evidence from well-designed studies shows no change in attitudes, knowledge or beliefs related to intimate partner and sexual violence.

Effectiveness unclear: Insufficient or mixed evidence, including programmes with weak evaluation designs and only one pilot.

The table below lists the category of effectiveness of each type of intervention assessed.

Table 15 Level of effectiveness of each type of intervention

TYPE	N	EFFECTIVE	PROMISING/ EMERGING	UNCLEAR	INEFFECTIVE	UNDER EVALUATION
Parenting	8	1	4	3	0	0
Targeted interventions for children or adolescents exposed to violence	3	3	0	0	0	0
School-based (broad)	15	3	10	1	1	0
School-based (dating violence)	7	2	3	1	1	0
School-based (sexual assault prevention)	10	1	3	3	3	0
Community based	16	4	8	3	0	1
Economic empowerment	2	0	0	2	0	0
Total	61	14	28	13	5	1

The review concluded that school based programmes promoting gender equitable attitudes and norms and community based interventions to promote egalitarian gender norms and attitudes both showed promise when implemented in LMIC contexts.

Table 16 Conclusions – what works in which contexts?

INTERVENTION	LEVEL OF EFFECTIVENESS	CONTEXT
Parenting programmes	Promising	HIC
Psychological interventions for children and adolescents exposed to maltreatment or parental IPV	Effective	HIC
School based dating violence prevention	Effective	HIC
School based promoting gender equitable attitude and norms	Promising	LMIC
School based rape awareness and knowledge programmes	Unclear	HIC
School based self defence training	Ineffective	HIC
School based confrontational rape prevention programmes	Ineffective	HIC
Community based to promote egalitarian gender norms and attitudes	Promising	Mostly LMIC
Economic empowerment interventions for adolescent girls	Unclear	LMIC

Policy and programme implications

(i) Target children and adolescents exposed to child abuse and parental interpersonal violence with psychological/psychotherapeutic interventions

- Key entry points for interventions
 - ✓ Working with parents
 - ✓ Schools
 - ✓ Community programmes including media
- Content of interventions:
 - ✓ Reducing trauma and stress, guilt, improving self-worth and sense of competence
 - ✓ Skills in managing relationship conflict in non-violent ways and in egalitarian gender relations
 - ✓ Non-violent discipline
 - ✓ Gender socialization and non-violent norms

(ii) Policy context needs to promote empowerment, equality, safety

- ✓ Legal reforms and enforcement of laws
- ✓ Reducing access to alcohol
- ✓ Budgetary allocations
- ✓ Improving institutional responses – child protection, school environment, legal, social services

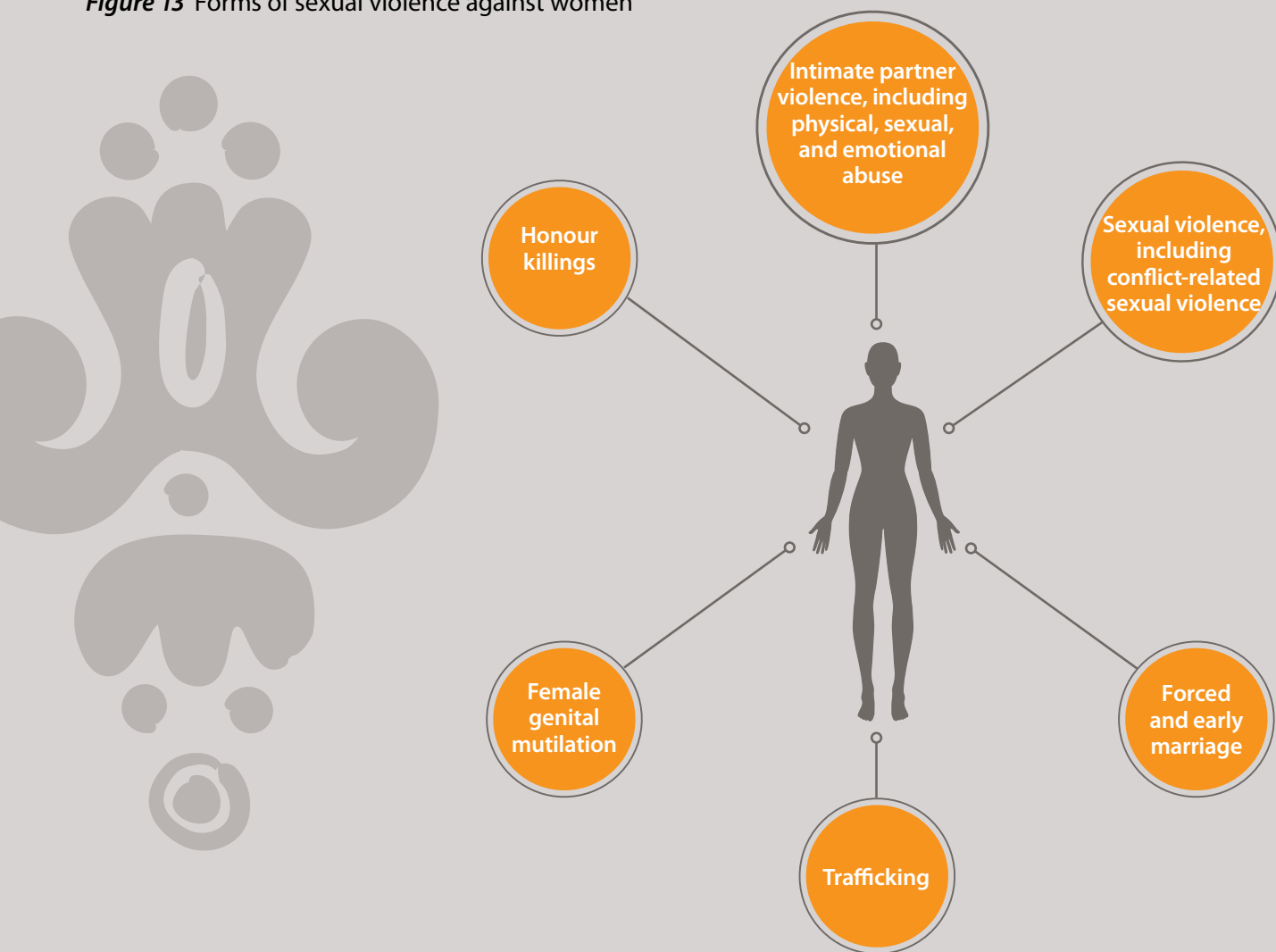


2.4.2 Violence against women: Evidence and actions

This presentation was prepared by **C Pallitto, C Garcia Moreno, L Say, and V Chandra-Mouli, Department of Reproductive Health and Research, WHO HQ.**

In 1993, the UN General Assembly passed the UN Declaration on the Elimination of Violence against Women. Violence against women is defined as “any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life” (United Nations 1993). This Declaration marked an important milestone in recognizing violence against women as a global human rights problem and in making governments responsible for action.

Figure 13 Forms of sexual violence against women



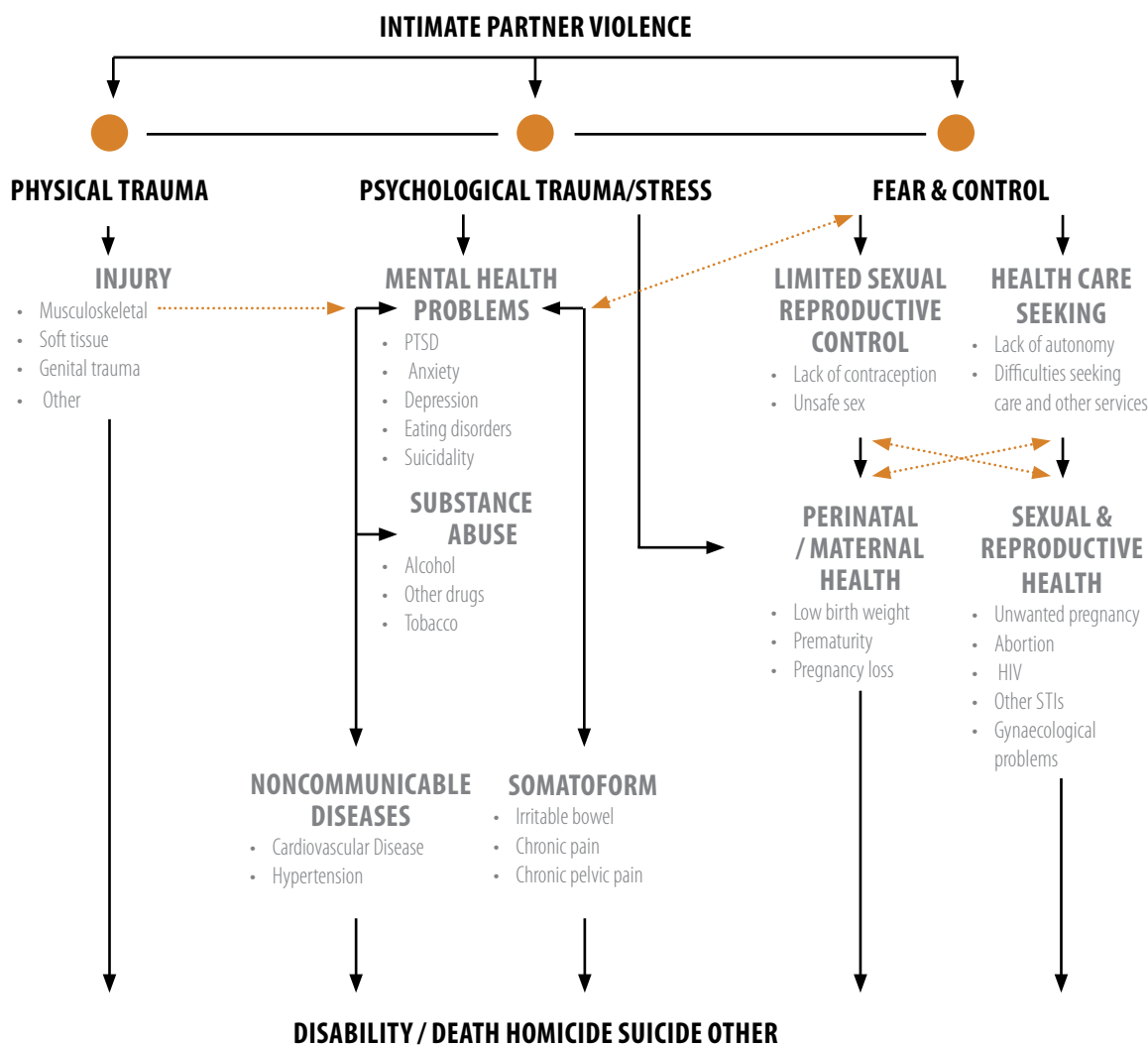
Source: United Nations. 1993

The document recognizes that violence against women takes many forms and identifies a range of types of violence, which are illustrated in the figure above. These include intimate partner violence (IPV) **defined as experience of one or more acts of physical and/or sexual violence and/or emotional/ psychological abuse by a current or former partner**, sexual violence (SV) by someone other than a partner, being forced into marriage and early marriage, female genital mutilation, honour killings, and trafficking.

In 2013, WHO released the first global and regional prevalence estimates of two forms of violence against women: (1) Intimate partner violence and (2) Sexual violence by a non-partner. The results showed that violence against women, and particularly IPV, is a global problem of significant magnitude - 30% of (ever-partnered) women globally have experienced some form of physical and/or sexual violence by a partner in their lifetime

Evidence from systematic reviews indicates that violence against women (VAW) has serious and lasting health consequences for the affected women (WHO 2013). The diagram below shows the pathways through which IPV can lead to the health outcomes that were studied as part of this exercise.

Figure 14 Pathways and health effects of intimate partner violence



Source: WHO. 2013

These health outcomes occur through three primary pathways:

- 1 **Physical trauma** can result in injuries or death – 42% who have experienced IPV have been injured as a result.
- 2 The **psychological trauma and stress** of IPV can lead to emotional distress or fear. This has been shown to lead to health problems and behaviours that can put women’s health at risk and also be dangerous for their offspring. For example, stress-related elevated cortisol levels can result in preterm birth and low birth weight (LBW) infants. It can also lead to harmful coping mechanisms such as alcohol use. Women who have experienced IPV are twice as likely to experience depression and almost twice as likely to have alcohol use disorders as compared to women who have not.
- 3 The third pathway shows how women living in relationships in which they experience **fear and controlling behaviours** by their partners may have limited control over their sexual and reproductive decision-making or their health seeking behaviour. Women who have experienced IPV are twice as likely to have an abortion and 1.5 times more likely to acquire HIV.



Effects of violence against women

Violence against women (VAW) has intergenerational health and socio-economic effects

– In addition to affecting women's health VAW also has an impact on families, communities, and societies. Research shows that children who witness or suffer violence during childhood are at greater risk of becoming abusive or of being abused in adulthood, perpetuating the cycle of violence across generations. Some of these effects are listed in the table below.

Table 17 Effects of violence against women on children, families and society

EFFECTS ON CHILDREN OF WOMEN WHO EXPERIENCE ABUSE	EFFECTS ON FAMILIES	SOCIAL AND ECONOMIC EFFECTS
<ul style="list-style-type: none"> • Higher rates of infant morbidity and mortality • Physical injury • Behaviour problems • Anxiety, depression, suicide • Poor school performance • Increased likelihood of experiencing & perpetrating violence as adults 	<ul style="list-style-type: none"> • Reduced ability to work • Lost wages • Impaired family function 	<ul style="list-style-type: none"> • Costs of services incurred by victims & their families • Lost workplace productivity • Perpetuation of violence

Risk and predisposing factors for violence against women

Childhood abuse and gender inequality are the main risk factors for violence against women.

Influences that contribute to VAW occur at individual, relationship or family, community and broader societal levels. Starting at a societal level, predisposing factors include: gender and social norms accepting of violence and ideologies of male entitlement; women's lack of access to education, employment and family resources; and lack or poor enforcement of laws and policies on violence against women and girls. Similarly at community level, identified risk factors include: unequal gender norms that condone violence against women and weak community sanctions. At the level of families or relationships: men's control over women; marital dissatisfaction; and multiple partners and at an individual level, factors that predispose women to abuse include: exposure to child maltreatment and to sexual abuse in men; low education and low income; separated or divorced status at a young age (in girls/women); acceptance of violence; mental disorders; and alcohol use.

Prevention of violence against women

Multilevel and multisectoral actions are needed to prevent violence against women

– The health sector can play an important role in responding to violence against women. Health sector plans to identify violence and mitigate its consequences must be developed in conjunction with other sectors. Whilst there is no intervention that can definitely prevent violence against women, the promising programmes tend to have the following elements in common:

- 1 They work across different sectors of society;
- 2 There are repeated doses of the intervention i.e. it is not a once-off activity;
- 3 They address multiple risk factors, including risk factors that operate at the individual level, the family/relationship level, the community level, and the societal level;
- 4 They address underlying causes such as gender inequality and norms that tolerate VAW;
- 5 They encourage autonomy and empowerment of women;
- 6 They are based in theories of change; and
- 7 They engage communities.

Examples of prevention programmes that have been shown to reduce violence against women and that have been replicated in other settings include:

- **Programmes that involve boys and men to reshape beliefs, attitudes and behaviours** e.g. Progam H, M, D. These have been implemented throughout the world and show how reshaping beliefs and behaviours around masculinity can be powerful in changing norms.
- **Programmes that challenge and change inequitable gender norms through micro-finance in conjunction with couple and community engagement** e.g. the IMAGE study (Intervention with Microfinance for AIDS and Gender Equity Study) showed reductions in poverty, a 50% reduction in IPV, and reductions in HIV risk behaviours.
- **Programmes that involve influential community members and institutions to address power dynamics and power inequalities between men and women** e.g. The SASA! Raising voices study showed that by addressing power dynamics and power inequalities between men and women, through involvement of community members, leaders and institutions, could result in reductions in violence and also in attitudes supporting violence. It was originally carried out in Uganda and has been replicated in 15 countries.

The health sector has a crucial role to play in preventing and responding to violence against women and can be an important entry point for identifying women who have experienced violence. Health care providers are in a unique position to address the health and psychosocial needs of women who have experienced violence, provided they are given the tools and training to respond appropriately.

Table 18 Health sector response to violence against women

REASONS FOR HEALTH SECTOR INVOLVEMENT IN THE VAW RESPONSE	EXAMPLES OF WHAT THE HEALTH SECTOR CAN DO
<ul style="list-style-type: none">• Most women attend health services at some point - particularly SRH services, including antenatal care (ANC)• If health workers know about a history of violence, they can provide better and more tailored care to their patients• There is an important human rights obligation to provide the highest standard of health care to patients	<ul style="list-style-type: none">• Provide comprehensive health services for survivors• Collect data about prevalence, risk factors and health consequences• Health providers can help inform policies to prevent VAW• Providers can implement programmes to prevent violence from happening again, or to prevent it from happening in the first place• Health workers can be important advocates for recognizing VAW as a public health issue.

WHO has developed two important tools to inform the health sector response to VAW: (1) Clinical and policy guidelines on the health sector response to IPV and sexual violence released in 2013; and (2) A clinical handbook released in 2015. The handbook is an abridged version of the guidelines, which gives providers practical guidance on how to respond appropriately and effectively to a woman experiencing violence. A women-centred health sector response includes:

- Being non-judgemental, supportive and validating;
- Providing practical care that responds to her concerns, but does not intrude;
- Asking about her history of violence, listening carefully, but not pressuring;
- Helping her access information about resources, including legal and other services; and
- Assisting her to increase safety for herself and her children

Globally there is growing commitment to end violence against women. At the WHA 2014, WHO member states resolved to strengthen the role of the health system within a multi-sectoral response to address violence, particularly violence against women, girls and children. Countries are urged to:

- Document violence against women and girls through data collection;
- Inter-face with justice systems for medico-legal aspects;
- Provide health services, particularly SRH services;
- Advocate and build evidence for prevention; and
- Implement health systems prevention interventions.

A Global Plan of Action has been developed and approved by WHO's Executive Board.

"All over the world, an alarming number of adolescent girls are assaulted, beaten, raped, mutilated and even murdered. The threat of violence at the hands of family members, partners, teachers and peers grossly violates their rights, diminishes their power and suppresses their potential. A culture of impunity allows violence against adolescent girls to continue unabated. Conflict and humanitarian crises dramatically increase the risk of violence, abuse and exploitation. This violence is exacerbated and reinforced by the multiple deprivations adolescent girls face, including unequal access to education, skills, information, sexual and reproductive health services, and social and economic resources."

Ban Ki-moon: Secretary General, United Nations
Statement on the International Day of the Girl Child 2014:
Empowering Adolescent Girls: Ending the Cycle of Violence.

2.4.3 Experience in addressing intimate partner and sexual violence in Ethiopia

Dr Luwam Teshome, FHP, WHO Ethiopia presented the Ethiopian country experience in addressing IPV and sexual violence.

Ethiopia's total population is 90 million people according to projected estimates from the 2007 census. The country is divided into nine Regions, two of which are city administrations, and 824 districts called Woredas. In excess of 84% of the population lives in rural areas and more than 41% fit into the adolescent and youth category. Women of reproductive age constitute 24% of the total population.

The table below provides an indication of the status of reproductive, maternal, neonatal and child health (RMNCH) in the country projected from UN estimates and previous demographic and health surveys (DHS)

Table 19 Status of RMNCH in Ethiopia (2013/2014)

INDICATORS	VALUE (2013/14)
Maternal mortality ratio	420*
Proportion of births attended by skilled health personnel	15%**
Contraceptive prevalence rate (15-19)	41%**
Adolescent Birth Rate (per 1000, age 15-19)	65**
Total fertility rate	4.1**
Antenatal care coverage - at least one visit	57% **
Antenatal care coverage - at least four visits	32%**
Unmet need for family planning (15-19 years)	33%***
Under-five mortality rate	64*
Infant mortality rate	44*
Neonatal mortality	28*
HIV prevalence	1.1%****

Key: * UN estimate 2013 ** mini DHS 2014 ***DHS 2011
****FMOH HIV projections 2014

According to UN estimates, the proportion of women reporting IPV and/or non-partner sexual violence (SV) is 36.1%. Recent studies indicate that 26% of high school students faced SV where 24% of them were less than 15 years of age. Sixty eight percent of respondents in the Ethiopian DHS conducted in 2011 agreed that wife beating is justified, including for refusing to have sexual intercourse with her husband or partner.

Ethiopia has taken a number of progressive steps to address IPV and SV. These include:

- The family law was revised in 2000 to protect the rights of women and children and to promote gender equality and equity;
- Similar revisions to the criminal law in 2005;
- In 2009 FMOH implemented a national **Clinical Management guideline for survivors of sexual violence** directed at health care providers;
- Incorporation of SGBV in the teaching curriculum of medical schools;
- A national taskforce is working on a multisectoral response to GBV;
- School based peer education programmes to delay sexual debut and safe sex for those who are sexually active;
- Routine services are offered at different levels of facilities;
- Model clinics for survivors of sexual violence were established at GMH, Adama & Hawassa referral hospitals in 2012.

- One stop service centers provide medical, psychological and legal support services in one place

These interventions have resulted in higher numbers of women and children coming forward to report violence as well as increased perpetrator prosecution and conviction rates. However, despite this significant progress, a number of challenges still remain to be overcome. These include:

- Limited public awareness on sexual rights - the EDHS 2011 showed that only 49% of respondents were aware of the laws against SV;
- Accessibility of services is a problem in many areas;
- Attitude of service providers presents a barrier;
- Lack of data on intimate partner and sexual violence;
- Sexual violence in general remains under-reported, and even when it is reported the conviction rate is very low;
- Socio cultural barriers - IPV is regarded as normal and acceptable; and
- Limited multisectoral collaboration hinders implementation of the law.

The way forward lies in strengthening the national taskforce working on the multisectoral response to GBV; advocacy to increase awareness; gathering information (survey) on the prevalence of SV-IPV and service availability; and scale up of services.

2.4.4 Being OTEKA together: The GREAT project

Sam Okello, Research, Monitoring and Evaluation Coordinator at the Institute for Reproductive Health (IRH) prepared this presentation on the GREAT project evaluation results on behalf of the consortium consisting of IRH, Pathfinder International, and Save the Children. This presentation was not delivered in person.

The GREAT project was funded by the United States Agency for International Development (USAID), initially for five years and then for a further six and a half. Global data shows that adolescents are an important age group that faces many challenges. When the project began in 2010 Northern Uganda, the location in which the project was implemented, was a post-conflict setting.

SITUATION OF ADOLESCENTS

Globally	Northern Uganda (2010)
<ul style="list-style-type: none"> • Adolescence as a key transition period • Comprise one third of the world's population • Face challenges in education, vocational skills, poverty, violence, poor social and health outcomes 	<ul style="list-style-type: none"> • Internally displaced persons (IDP) camps close and families return • Adolescents witnessed extreme violence and experienced loss • Disrupted services and traditions • Economic and physical insecurity

As a gender roles, equality and transformation project, GREAT addresses social norms.

Gender roles and norms influence health and wellbeing – Ideas about men and women's roles affect adolescent SRH and GBV. GREAT shifts social norms and attitudes to foster healthier, more equitable behaviours. It does this by correcting misinformation, sparking critical reflection, changing expectations for appropriate behaviour and supporting groups to take action. This helps to create a gateway to positive health and well-being for adolescents and their communities.

Young people's health and wellbeing is influenced by their family, community, institutions and environment – Young people's ability to forge healthy sexual relationships and to support themselves financially is influenced by their family, community, institutions and environment. GREAT diffuses new ideas and information through different levels of the community to support individual change.

Making a real difference requires reaching enough people in a community to spread new ideas and information to support individual change – People were reached through different levels of the community by using existing youth and community groups such as school-based clubs and village savings and loans associations with minimal additional resources.

The GREAT project is unique in that it:

- Is inspired by local information on the context in Northern Uganda;
- Is developed with community members and leaders;
- Incorporates learnings from reviews of effective youth programmes;
- Reaches the majority of people with modest time and money; and
- Is simple and addresses different life stages.

GREAT is composed of four main elements –

1 Community action cycle (CAC) – Community action groups (CAG) conducted activities that included sensitization, support to use the toolkit, home visits and advising families. The CAC consists of the following steps: (i) Prepare to mobilise; (ii) Organise the community; (iii) Explore gender equality, ASRH and GBV; (iv) Plan together; Act together; and (v) Evaluate together.

2 Serial radio drama – The Oteka Radio Drama is a 50-episode serial radio drama aired on local radio stations across the implementation areas. It tells the stories of several families in the fictional village of Oteka who are faced with challenging decisions related to relationships, sexuality, violence, alcohol, sharing of resources and responsibilities, and parenting. It aims to promote dialogue and generate excitement and interest in community rebuilding and cultural revitalization with respect to SRH, gender equity, and gender-based violence and to motivate young people to engage in GREAT project activities.

3 Strengthen – Creating Village Health Teams (VHT) to service linkages - Training is provided to existing VHTs to strengthen their ability to meet the SRH needs of adolescents, reduce stigma of SRH service delivery to adolescents, improve referral systems for adolescents, and provide more gender-sensitive services to all community members. Training and support are also provided to facility-level staff to enable them to deliver respectful care. Links between GREAT groups and VHT, for example using activity cards and games that include inviting the VHT to a meeting or visiting the health center

4 Toolkit – Complementary components consist of 'Growing up GREAT' Flipbooks, Radio discussion guides, Activity cards and 'You're GREAT' Community game. The project was implemented between October 2010 till October 2014 in Amuru and Lira Districts. Pabbo and Lamogi sub-counties were the intervention sites in Amuru and Amuru Town Council (TC) served as the control. Intervention sites in Lira District were Amach and Ogur sub-counties and the research control area was Barr sub-county.

The project worked with many actors to design and implement the vision. These included community and cultural leaders, Child Protection Committees, Government ministries, radio stations, District and sub-county officials, 60 VHTs, 171 Community Action Group members and teachers as well as community members.

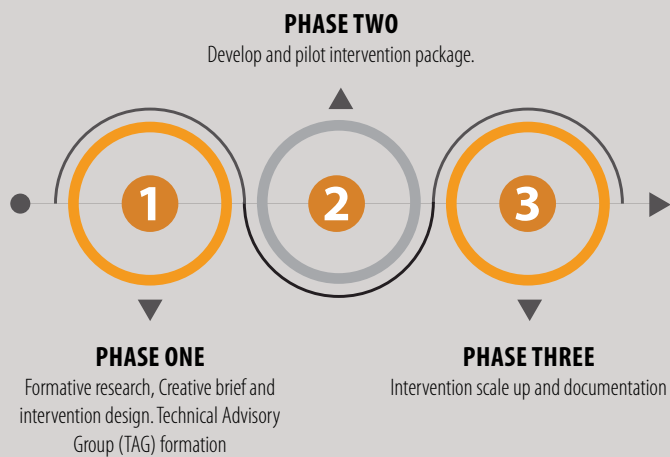
2.4.5 Being OTEKA together: GREAT project results

This part of the presentation shared the results, lessons learnt as well as next steps and opportunities arising from the GREAT end-line evaluation.

The study aimed to answer the question: Does participation in GREAT make a difference in the lives of adolescents? It was designed to move from research to action as results will inform the next phase of the project.



Figure 15 Moving from research to action in the GREAT project



Key research questions

- 1 Do adolescents exposed to GREAT have improved attitudes and behaviours related to:
 - Equality between men and women?
 - Couple relationships and family planning?
 - Gender-based violence?
- 2 Do adults exposed to GREAT provide advice to adolescents about equality, couple relationships, family planning and GBV?

Evidence to inform GREAT was gleaned from two sources – (1) Discussions among the consortium partners and (2) Consultations with local communities and leaders. These consisted of:

- Baseline to end-line survey of 4, 500 adolescents and adults
- Cohort study with in-depth interviews with 30 male and 30 female adolescents
- Qualitative assessment of 152 adolescents and VHTs involved in GREAT
- Monitoring data was collected from Community Action Groups (CAG)s, VHTs, group and club leaders, and radio stations.

There were no large differences between baseline and end-line surveys or between the intervention and control groups.

Participants had the following characteristics:

- ✓ Most had a primary school education
- ✓ Catholic
- ✓ Low employment rate
- ✓ Most of the older cohorts were married
- ✓ Half were heads of household
- ✓ Most had a trusted adult to speak to

The table alongside shows the overall exposure to GREAT in the intervention and control areas. Figures depicted in **bold** indicate a

greater than 5% difference from the control group.

Table 20 Overall exposure to GREAT: intervention and control areas

AGE	RADIO	VHT	CAC	TOOLKIT
10-14	78%	12%	8%	40%
15-19	59%	9%	5%	3%
Newly married or Newly parenting	58%	22%	7%	5%
Adults	62%	25%	10%	2%

Results – highlights

- Participants – young people and old – enjoyed being involved in GREAT and felt that it resulted in positive changes in themselves, their families, and their communities.
- Participation in GREAT activities helped to change attitudes related to men and women’s roles, relationships, sex, family planning, and GBV.
- Adults exposed to GREAT were significantly more likely to give young people advice on these topics.
- Those engaged in GREAT had more gender-equitable attitudes, although changes in behaviour were not as frequent. Fewer older adolescents exposed to GREAT held inequitable gender norms compared to those who had not been exposed to the programme (37% of those exposed compared to 48% not exposed).
- Educating girls promoted the health and well being of families and communities. Fewer newly married or newly parenting youth exposed to GREAT (36%) believe that it is more important for boys to be educated than girls, compared to those who were not exposed (56%).
- **Gender equality** – More gender equitable behaviours were also seen, especially among newly married or newly parenting adolescents. Newly married or newly parenting male adolescents exposed to GREAT were more likely to be involved in childcare (51% of those exposed versus 42% not exposed) or helping with household chores than those not reached (65% exposed versus 53% not exposed).
- **Sexual and reproductive health** – Most young people who participated in GREAT showed improved attitudes and behaviours related to SRH. Older adolescents and newly married or parenting youth exposed to GREAT were more likely than those not exposed to hold positive attitudes towards contraceptive use, talk to their partner about the timing of their next child and discuss contraceptive use. Newly married or parenting couples were also more likely to seek and used contraception. Forty



three percent (43%) of newly married or parenting youth exposed to GREAT used contraception compared to 33% of a similar group who had no exposure to GREAT. Similarly 35% of the exposed group was seeking FP compared to 19% who were not exposed.

- **Gender based violence** – Changes in social acceptance of men’s use of violence to control their wives take time to occur, however improved attitudes and less violence was seen among adolescents involved with GREAT. There was a significant decrease in newly married or parenting women and men who report reacting violently to their partner when they are angry – 5% (exposed) versus 21% (not exposed). In addition, fewer older adolescents reported touching or being touched on the behind or breast without permission in the last three months – 12% of older adolescents not exposed to GREAT and 4% of older adolescents exposed to the programme.
- **Enabling environment** – Improving youth outcomes requires adults to support more equitable attitudes and behaviours. The adults exposed to GREAT were significantly more likely to advise young people on gender, couple relationships, avoiding pregnancy and partner violence – 61% compared to 50%, respectively.

Lessons learned

- **Include girls and boys in addressing social norms and community change** – These results demonstrate that programmes that are comprehensive can make a difference. Focusing exclusively on girls and young women will **not** solve the problem. GREAT engages girls and boys, together and apart and the radio programme reached more males.
- **Work with youth, parents, community leaders and other community members to make a lasting change** – The greatest results come from working with individuals, families, and communities and making sure to meet the challenges and opportunities presented by the

different adolescent and other life stages.

- **Tailor activities for specific life stages e.g. younger adolescents, newly married couples** – In terms of life stages, newly married couples had very good results and this seems a good time to intervene.

These lessons have informed key revisions to the GREAT intervention package as indicated in the table below.

Table 21 Key revisions to GREAT intervention package

OTEKA: Improve coverage and listener interaction	PLATFORM: Simplify to improve cost and leader facilitation skills
<ul style="list-style-type: none"> • Create buzz • Provide non-radio options e.g. scripts for drama clubs, mobile SIM cards • Adjust air time (women, very young adolescents (VYA), and older adolescents (OA)) 	<ul style="list-style-type: none"> • Reduce cost • Expand to secondary schools • Standard toolkit across age cohorts • Simplify language, Referential Dependencies Graph (RDG) – a modeling technique or method to simplify language) • Add facilitation tips
CAG: Improve efficiency, cost, and effectiveness of CAGs	VHT: Improve attitudes towards adolescent FP use
<ul style="list-style-type: none"> • Work with existing structures • Include platform leaders and PTA reps in CAG • CAGs at village level • Simplify community action cycle training, where possible 	<ul style="list-style-type: none"> • Use MOH reporting format • Incorporate gender and values clarification and myths/misconceptions in MOH training manual • Train 2 VHTs per village and link to service providers (MSU, FHI 360 etc.)

Opportunities for positive youth development

- Scaling up GREAT in Northern Uganda.
- Everyone has a role in helping youth grow up to be healthy, happy adults.
 - Things that community members and health providers can do:**
 - Talk with others about how ideas about appropriate roles for men and women influence adolescent relationships and health;
 - Support men who oppose violence;
 - Support the dreams of their sisters and wives who want to finish their education or take on new responsibilities;
 - Support couples that choose to use family planning to delay their first pregnancy and ensure healthy spacing between their children; and
 - Support access to family planning and sexual health information and services for adolescents.
 - Things that district leaders and program managers can do:**
 - Invest time and resources into programmes like GREAT, which provide youth with opportunities for healthy development– include them in work plans and budgets, seek funding for them and help to coordinate ongoing activities for youth;
 - Prioritize programs that address gender norms; and
 - Expand access to youth friendly sexual and reproductive health services.

More information on the GREAT project is available at www.irh.org/projects/GREAT_Project

2.5 Creating an enabling environment for ASRH

Key messages from the Journal of Adolescent Health Supplement

Creating an enabling environment for adolescent sexual and reproductive health and rights: A framework and promising approaches

Evidence from research:

- Individual behaviours are shaped by factors that operate at the individual, relational, family, community and societal levels.
- There are promising approaches to build protective factors and address risk factors at the individual level e.g. building individual assets; relational level e.g. working with parents and peers; community level e.g. challenging and changing community norms; and the societal level e.g. formulating and applying enabling laws and policies, and increasing investment.
- There has been only limited research or rigorous evaluation in this area.

Lessons from implementation experience:

Most efforts are piece-meal, small scale and time limited

Implications for action:

- Adapt and apply the promising approaches to the realities of different contexts, using a multi-level approach.

Implications for research:

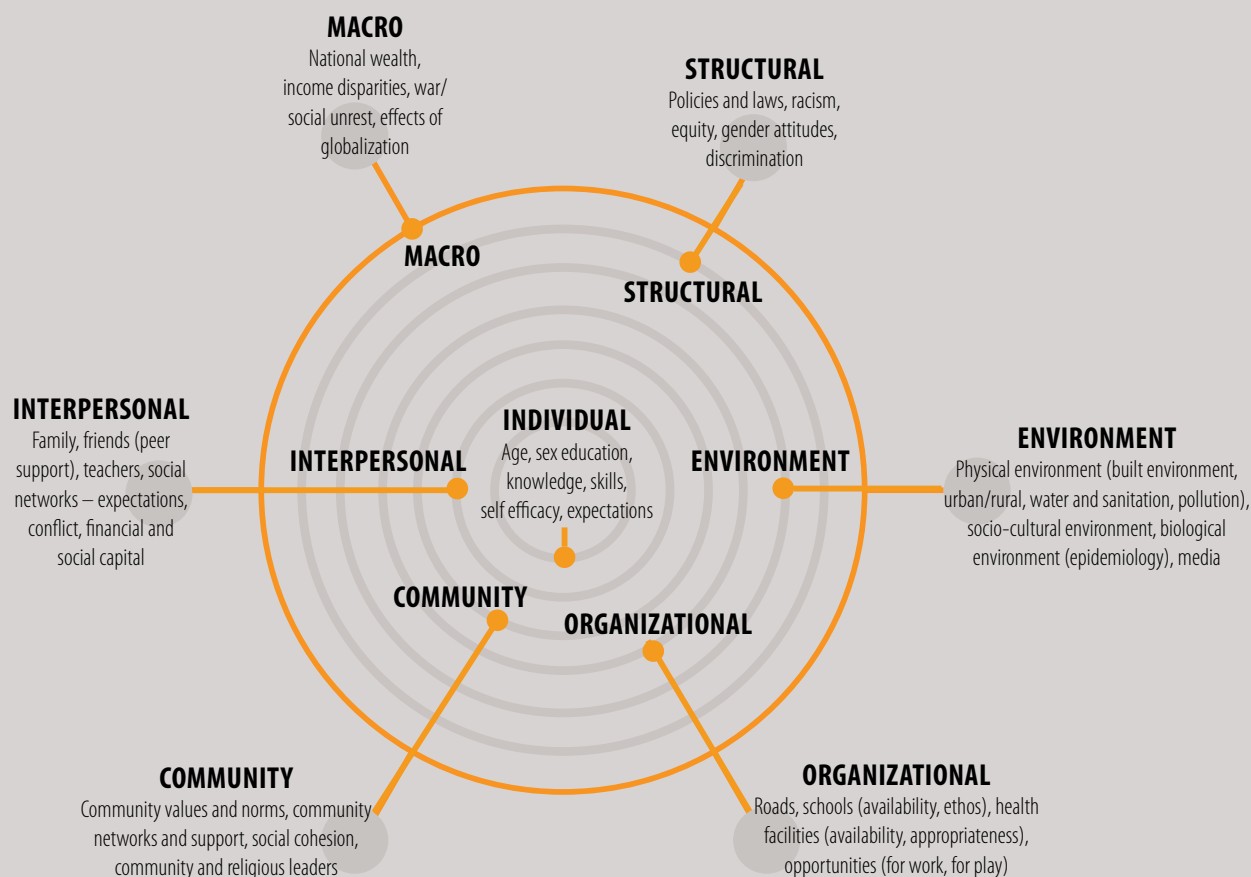
- Carry out research and more rigorous evaluations.

2.5.1 Enabling environment for ASRH: Adolescent health in all policies

This presentation, by **Valentina Baltag, Department of Maternal, Newborn, Child and Adolescent Health, WHO**, highlighted the need to include adolescent health in all policies.

Today, not only do we know more about mortality, disability adjusted life years (DALYs) and health-related behaviours, but we also have a much better understanding of the determinants that can either undermine or protect adolescent health and development. These factors are illustrated in the figure below.

Figure 16 Determinants of adolescent health



Examples of legislation, regulations and policies pertinent to adolescent health –

- Tobacco and alcohol control policies:
 - Set drink-driving laws that are based on blood alcohol concentration (BAC) levels, or equivalent breath alcohol concentration levels. BAC should be $\leq 0.05\text{g/dl}$ for the general population, while the lower level of $\leq 0.02\text{g/dl}$ is recommended as the cut off for young or novice drivers.
 - Implement graduated licensing for novice drivers graduated with zero-tolerance for drink-driving.
- Age of marriage;
- Child protection regulations;
- Abortion laws; and
- Child pornography.
- Health system policies:
 - Adoption of quality standards;
 - Confidentiality;
 - Financial protection;
 - Informed consent;
 - Comprehensive package of services;
 - Data disaggregated by age and sex;
 - Adolescent health competency-based education and training in pre-service and in-service curricula; and
 - Information and media used in health promoting programmes and health education campaigns should provide tailored information.
- Labour sector policies:
 - Opportunities for youth to secure decent work; and
 - Labour protection policies targeted at youth.
- Community involvement policies:
 - Community participation; and
 - Training for good parenting practices.

What's new in the Health for the World's Adolescents Report

- Explicit focus on the role of the health sector in improving and maintaining the health of adolescents;
- Current thinking about the importance of focusing on adolescent health for public health across the life cycle;
- Mortality and DALY trends (data visualization);
- Prevalence & trends in health behaviour in countries (data visualization);

- One stop shop for WHO guidance across all health issues concerning adolescents;
- Global standards for improving health service delivery for adolescents;
- Implications of universal health coverage for adolescents;
- Adolescents' perspectives of their health needs, health services and policies;
- Primary care providers views on addressing adolescents' needs; and
- An analysis of the attention paid to adolescents in national health policies and strategies and in mental health policies

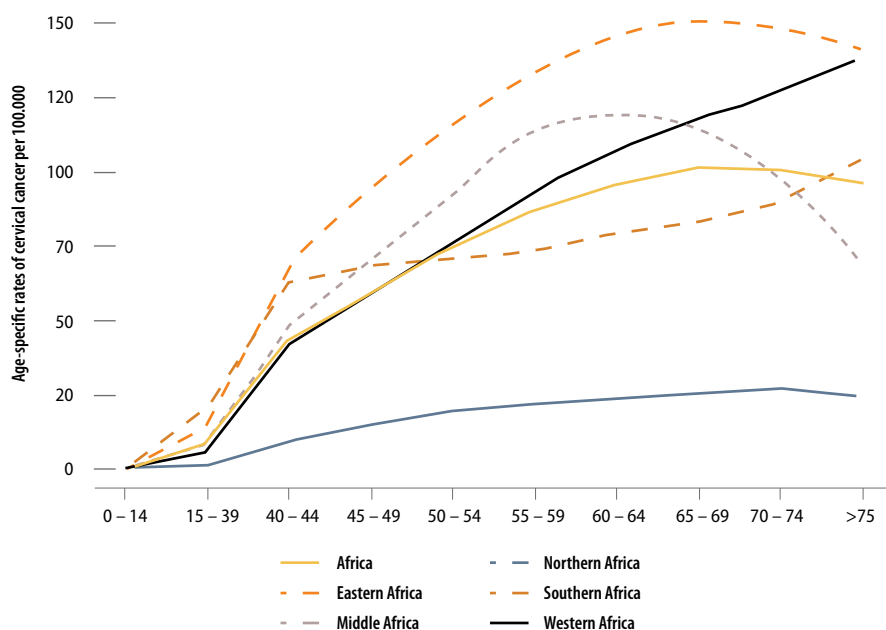
Investments in adolescent health maximize human capital via three trajectories - Firstly by improving and maintaining the health of adolescents; Secondly, by benefiting the next generation; and Thirdly, by reducing the burden of disease in later life (<http://apps.who.int/adolescent/second-decade/>).

2.5.2 Human Papilloma Virus (HPV) Vaccine introduction: An opportunity for improving SRH of adolescents in Africa

This presentation by *Symplice Mbola Mbassi, WHO* describes the benefits of HPV vaccination programmes.

Cervical cancer is among the leading causes of death among African women. The latest data available (2012) from the International Agency for Research on Cancer (IARC) estimate that worldwide the cervical cancer mortality rate or case fatality ratio is 50% - this means 50 of 100 women diagnosed with cervical cancer every year die from it. Co-infection with HIV results in cervical cancer presenting earlier. This is illustrated in the figure below, which clearly indicates the higher incidence in younger women observed in Regions with a high HIV burden such as Eastern and Southern Africa. The yellow and red lines respectively represent these regions in the diagram.

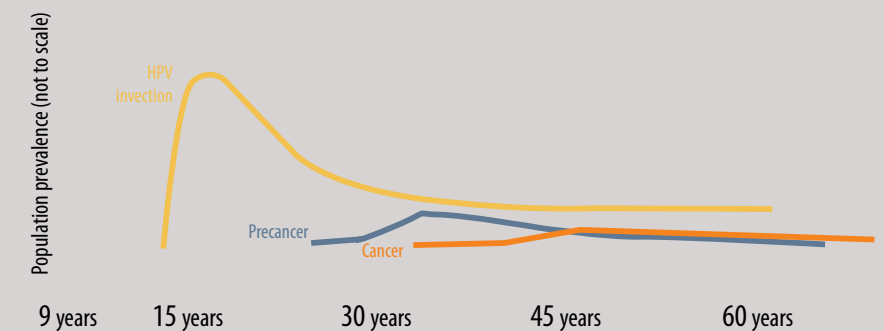
Figure 17 Age-specific cervical cancer rates in Africa (2012)



The response to cervical cancer requires a comprehensive approach, including interventions during adolescence and also across the later life stages. Vaccination is a highly effective preventive measure that will avert 70% of cancers. However, vaccination programmes must be implemented together with other interventions – sexuality education, access to condoms, and medical male circumcision (MMC). WHO promotes the use of HPV vaccine and recommends a two-dose schedule for 9-13 year old girls, with the second dose provided at least 6 months and up to 12 - 15 months after the first dose (WHO 2014).

The figure below demonstrates the various primary, secondary and tertiary prevention measures for cervical cancer that can be put in place during adolescence, the reproductive period, and in the post-reproductive phase.

Figure 18 Comprehensive approach to cervical cancer prevention



Primary Prevention
Girls 9-13 years

- HPV vaccination

Girls and boys, as appropriate

- Health information and warnings about tobacco use*
- Sexuality education tailored to age and culture
- Condom promotion/provision for those engaged in sexual activity
- Male circumcision

Secondary Prevention
Women >30 years of age
Screening and treatment as needed

- "Screen and treat" with low cost technology visual inspection with acetic acid (VIA) followed by cryotherapy
- HPV testing for high risk HPV types (e.g. types 16, 18 and others)

Tertiary Prevention
All women as needed
Treatment of invasive cancer at any age

- Ablative surgery
- Radiotherapy
- Chemotherapy

* Tobacco is an additional risk factor for cervical cancer

GAVI, the Vaccine Alliance, provides support for the introduction of HPV vaccine in the form of demonstration programmes as well as support for the national introduction of HPV vaccine. A number of African countries are starting to introduce the vaccine. A list of countries providing HPV vaccination, either through national funds or with GAVI support, is tabulated below.

Table 22 African countries providing HPV vaccine

NATIONAL FUNDS	WITH GAVI SUPPORT		
	National introduction	Demonstration projects started	Demonstration projects to start 2015/16
Lesotho	Rwanda (2014)	Cameroon	Benin
South Africa	Uganda (2015)	Gambia	Burundi
Seychelles		Ghana	Cote d'Ivoire
Botswana		Kenya	Liberia
		Madagascar	Mali
		Malawi	Burkina Faso
		Mozambique	Ethiopia
		Niger	
		Senegal	
		Sierra Leone	
		Tanzania	
		Togo	
		Zimbabwe	

The introduction of HPV vaccination programmes presents at least three opportunities : **Reaching 9-13 year old girls** – HPV vaccination programmes provide a unique opportunity to reach girls during early adolescence when they are at a vulnerable period of their lives and when there are few interventions targeted specifically for this age group.

High coverage – HPV vaccination programmes cover the majority of girls. Reported coverage figures range from 84% (HPV vaccination evaluation, Bhutan 2014) to 95% in Rwanda (Binagwaho 2012) and provide a good starting point for SRH.

Integrated approach to adolescent health – integrating HPV vaccination with adolescent health interventions and programmes creates linkages with the potential to make HPV delivery more efficient and sustainable and provides an opportunity for reaching girls and boys with additional health interventions and benefits (WHO 2014).

Table 23 HPV vaccination programme linkages in various countries

PROGRAMME LINKAGE OR INTERVENTION	COUNTRY
Vaccine delivery through school health programmes	<ul style="list-style-type: none"> • Panama • Malaysia • Bhutan, • Seychelles • South Africa
Strengthen health workers capacity for adolescent health care	<ul style="list-style-type: none"> • Madagascar • Malawi
EPI	<ul style="list-style-type: none"> • Bhutan – Td • Sierra Leone – Td • Rwanda - MR
Deworming	<ul style="list-style-type: none"> • Madagascar
Puberty and Health education messages	<ul style="list-style-type: none"> • Malawi - Adolescent growth & development, Menstrual hygiene, HIV prevention
Promoting Cervical cancer screening (mothers)	<ul style="list-style-type: none"> • Malawi

WHO resources on HPV Vaccine are available on the HPV Vaccine Introduction Clearinghouse website <http://www.who.int/immunization/hpv/en/index.html>

HPV vaccine programmatic resources <http://www.who.int/diseases/hpv/resources/en>

2.5.3 Addressing girls’ and boys’ ASRH needs at puberty, including menstrual hygiene management (MHM): Experience in creating an enabling environment for ASRH

Dr Venkatraman Chandra-Mouli delivered this presentation on behalf of **Dr Marni Sommer, Mailman School of Public Health, Columbia University**. Dr Sommer was not physically present, she sent her slide set.

Menarche is the dramatic entry into reproductive life and is therefore a critical moment at which to start talking to girls. It provides an entry point for talking about SRH and developing an early understanding of the body **before** family planning. Safe sex interventions **pre-pubescence** could be more impactful.

How can we provide an enabling environment for ASRH for girls and for boys?

Menstrual Hygiene Management - UNICEF plays a lead role in WASH in Schools, a project encouraging countries to address inadequate water, sanitation, and waste disposal for

menstruating girls. UNICEF has co-hosted, with Columbia University, three virtual conferences on MHM in WASH in Schools and has secured funding from Canada’s Department of Foreign Affairs, Trade and Development (DFATD) to conduct MHM research in 14 countries.

Puberty Books – The Girl’s Puberty Book was originally developed in Tanzania and aimed at providing 10-14 year old girls with information on early puberty and MHM. The book was approved by the Ministry of Education (MOE) and to date, over 420 000 copies have been distributed in Tanzania. The book has since been adapted to and approved by the MOEs of Ghana, Cambodia and Ethiopia. All are available for download on mobile devices – smartphones and e-readers – at <http://www.growandknow.org/books.html>

The books are designed for girls to take home to share with parents, out- of-school girls and siblings. They are published locally in each country and are easy to order. To date over 800 000 copies have been distributed across the four countries. UN agencies, MOEs, NGOs and religious groups use the book to conduct puberty trainings. Evaluations in all four countries found that the project contributes to enhancing parent-child communication.

There is a need for a Boy’s Puberty Book as boys impact on girls’ ASRH. Boys also have their own problems that need to be addressed as demonstrated by this quote; *“The first day I found myself ejaculating, I saw myself as a sick person. I thought it was a disease called syphilis...because of the stories I heard from my friends. I decided to keep quiet.”* (Adolescent boy student, urban Tanzania).

Tanzania has developed a Boy’s Puberty Book which incorporates relevant topics for girls, such as menstruation, sexual development, GBV, and peer pressures as well as issues like body changes, peer pressure and violence, that relevant for boys. Engaging boys and men on topics relevant for girls was informed by findings regarding boys bullying girls about menstruation from studies conducted by Save the Children Fund (SCF) and Emory-UNICEF in Ethiopia and also the Columbia University findings

from Ghana regarding girls wanting their fathers and brothers to read the book.

In terms of further action needed for ASRH, the MHM in Ten meeting held in 2014 identified five priorities for improving MHM in schools by 2024 (UNICEF 2014). There is a need for:

- Engagement from ASRH services to play a role in educating girls, boys and their parents on ASRHR;
- Beginning programming much earlier – at menarches; and
- ASRH to play a role in improving health facilities for MHM.

2.5.4 Creating an enabling environment for adolescent sexual and reproductive health in the Democratic Republic of Congo

The Democratic Republic of Congo (DRC) covers a geographic area of 2 345 000 km² and has a population of 70 million inhabitants. Adolescents and youth make up 32.8% of the population.

The DRC has established a policy environment conducive for ASRH and has a specialized adolescent and youth sexual and reproductive health programme. The programme has led the development of a national adolescent health policy and a national adolescent health strategic plan (2015). The normative environment is characterized by the development of the following norms and standards:

- Minimum package of services tailored to adolescents and youth;
- Training modules for clinical providers;
- Training module for community health workers;
- Guidance on adolescent and youth sexual and reproductive health;
- Information, education and communication (IEC) and behaviour change communication (BCC) materials; and
- National quality standards for adolescent and youth health services.

Youth centres create an enabling environment for service delivery. These are multifunctional structures that provide adolescents and youth with SRH services, including prevention, treatment and care. This vertical approach has now been

replaced with integrated adolescent friendly health services (AFHS). In 2014 there were 60 AFHS centres and this number had increased to 343 centres in 2015. The package of activities provided to adolescents and youth includes:

- IEC/BCC activities;
- HIV testing and counseling;
- SRH counseling;
- Contraception;
- Antenatal and postnatal care;
- Management of sexual violence; and
- Abortion care etc.

Part of creating an enabling environment is the organization and operation of an information space for adolescents and youth. The purpose is to provide information and services to adolescents and youth with a view to help them better understand issues that affect young people. The location and operating hours of the information spaces is well publicised. Key features include:

- Participation by adolescents and youth under the supervision of a trained health provider;
- Staff availability and friendly environment;
- Attractive space with photos and explanatory posters;
- Confidentiality and privacy safeguards;
- Availability of condoms; and
- Organisation of community activities as well as sports, cultural and recreational events etc.

The following activities are carried out to establish and maintain a community environment supportive of adolescent and youth sexual health:

- IEC/BCC pertaining to SRH in the community;
- Sexuality education in the family (parents) and in school;
- Training of peer educators;
- Training of community and religious leaders; and
- Counter misinformation in the community etc.

Challenges

Despite this huge effort and commitment a number of challenges still persist, such as:

- Community involvement is limited – dialogue between parents and adolescents around sex remains taboo;

- The budget allocated to adolescent health remains low;
- Adolescent health services require strengthening in more than 50% of health districts;
- Need to abolish the law passed in 1920 to prohibit the provision of contraception to adolescents;
- Persistence of sociocultural (customs and religion) barriers that need to be addressed; and
- Coordination and partnerships with other sectors and NGOs remain a crucial issue.

Opportunities and recommendations

- Scale up integration of the adolescent health package in health facilities;
- Develop a national adolescent health strategy 2016-2020;
- Strengthen multisectoral collaboration; and
- Conduct research to identify adolescent needs, particularly in the age group 10-14 years.

2.6 Promoting adolescent health, beyond sexual and reproductive health

2.6.1 Highlights from the Health of the World's Adolescents Report

This presentation by **Dr Valentina Baltag, Scientist, WHO/HQ** highlighted key findings from the WHO World's Adolescent Report, 2014. The report describes why adolescents need specific attention, distinct from children and adults. It presents a global overview of adolescents' health and health-related behaviours, including the latest data and trends, and discusses the determinants that influence their health and behaviours. Importantly, it features adolescents' own perspectives on their health needs.

The report brings together all WHO guidance on adolescents across the entire spectrum of health issues. It offers a state-of-the-art overview of four core areas for health sector action:

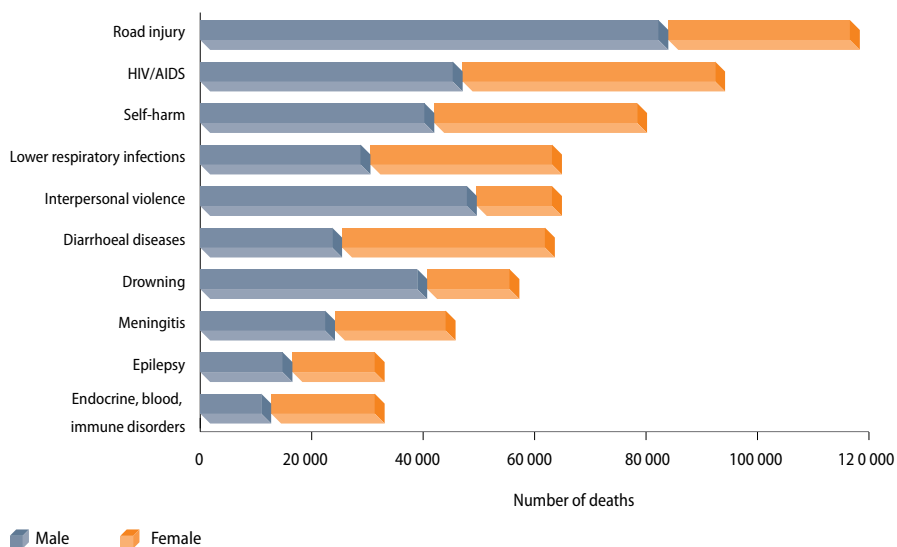
- i Providing health services;
- ii Collecting and using the data needed to advocate, plan and monitor health sector interventions;
- iii Developing and implementing health-promoting and health-protecting policies; and
- iv Mobilizing and supporting other sectors.

This report highlights a new analysis of the

main causes of death, illness and disability among adolescents showing that deaths due to complications of pregnancy and childbirth among adolescents have declined significantly since 2000. This decline is particularly noticeable in the regions where maternal mortality rates are highest. The South-East Asia, Eastern Mediterranean and African Regions have seen declines of 57%, 50% and 37%, respectively. Despite these improvements, maternal mortality ranks second among causes of death of 15–19-year old girls globally.

On the other hand, some infectious diseases are still major causes of death among adolescents. The leading causes of death among adolescents in 2012 were road injury, HIV, suicide, lower respiratory infections (LRTIs) and interpersonal violence. There are three important differences between the 2000 and 2012 adolescent mortality data. There have been marked declines in mortality from maternal causes and from measles, which show that we can make a difference when the political will and resources are available. However, HIV-related deaths have increased significantly at a time when HIV-related deaths were decreasing in all other population groups. This increase occurred predominantly in the African Region and is probably the result of improved treatment for paediatric HIV while the health services are not yet able to deal effectively with HIV in adolescence.

Figure 19 Top 10 causes of global deaths among adolescents by sex (WHO 2014)



The major causes of disability adjusted life years (DALYs) changed little between 2000 and 2012. In 2012, depression, road injuries, iron-deficiency anemia, HIV and intentional self-harm were the top five global causes of DALYs for adolescents. The one notable change from 2000 was that HIV ranked fourth among causes of DALYs in 2012 whereas in 2000 HIV did not feature in the top-10 list at all.

Not only do we know more about mortality, DALYs and health-related behaviours, but we also have a much better understanding of the determinants that either undermine or protect adolescent health and development. The report pulls together a range of services and interventions that can be provided to adolescents using different service delivery platforms, such as health facilities and schools. It also provides the results of a review that was carried out to explore the adolescent component of universal health coverage, which identified important implications for financing, human resources for health (HRH) and the quality of the services. The report also synthesizes the work that WHO has been carrying out on the development and monitoring of quality standards for health services for adolescents.



The report concludes with key actions for strengthening national health sector responses to adolescent health. It seeks to focus high-level attention on health in the crucial adolescent years and to provide evidence for action across a range of adolescent health issues. Thus, it addresses primarily senior and mid-level staff of ministries of health and health sector partners, such as NGOs, UN organizations and funders. It would also be of likely interest to other stakeholders – for example, advocates, service providers, educators and young people themselves.

2.6.2 Mental health in children and adolescents

Dr Sebastiana da Gama Nkomo, from the **Mental Health, Violence and Injury (MVI) Unit in the Non-Communicable Diseases (NCD) programme, WHO AFRO** delivered this presentation focusing on mental health and substance abuse in children and adolescents.

Mental health (MH) is defined as a total balance of the individual personality, considered from the biological and psychosocial points of view. Mental disorders are illnesses characterised by abnormalities in the emotional, cognitive or behavioural spheres. The field of mental health includes the prevention, treatment and rehabilitation of mental disorders.

Poor MH impacts the broader health and development of adolescents and is associated with several negative health and social outcomes. These include issues such as harmful use of alcohol, tobacco and illicit substances; adolescent pregnancy; school drop out; and delinquent behaviours. Healthy development during childhood and adolescence contributes to good mental health and can prevent mental health problems.

Key statistics

- Children below the age of 16 years make up half of the population in the Region.
- It is estimated that 3% of children aged 0-9 years suffer from a mental disorder such as mental retardation, autism spectrum disorders, epilepsy, depression, anxiety, and

traumatic stress disorder.

- 1 in 7 children and adolescents have significant difficulties in adaptation.
- 1 in 10 children have a specific psychiatric disorder.

Many children suffer from poor psychosocial development because of neglect by their mothers and other caregivers; this neglect may be due to lack of social support for the mother or to post-natal depression. Brain damage during birth is one of the main causes of serious mental health problems related to mental retardation.

Parents and health workers should be aware that for many teenagers peer and/or other types of pressure could lead to one or more of a variety of mental health problems - all are matters of concern, and some are life threatening.

Warning signs of possible mental illness in adolescents include:

- Excessive sleeping, beyond the usual **teenage fatigue**, which could indicate **depression** or **substance abuse**;
- Difficulty in sleeping – insomnia and other sleep disorders;
- Loss of self-esteem;
- Unexpected and dramatic decline in academic performance;
- Personality shifts and changes, such as aggression and excessive anger that are very out of character could indicate psychological, drug or sexual problems;
- Traumatic stress is especially high during and after a severe emergency event and in children who are living in foster care as a result of abuse and neglect;
- Self-mutilation or mention of self-harm;
- Obsessive body-image concerns;
- Excessive isolation; and
- Abandonment of friends and social groups.

There are a number of resource-related challenges related to providing MH services for adolescents – there is poor service coverage for children and adolescents with MH problems in low and middle income countries and a lack of motivated and trained personnel to respond to child and adolescent MH needs. In fact, little is known about the resources that would be required to provide these services within our African Regional settings.

WHO is strengthening the provision of MH services to children and adolescents through the implementation of the MH Gap Action Programme (mhGAP). This programme supports scale-up of care for mental, neurological and substance abuse disorders, especially in LMIC. The programme asserts that with proper care, psychosocial assistance and medication, tens of millions could be treated for their MH problems, prevented from self-harm and begin to lead a normal life - even where resources are scarce.

An accompanying intervention guide has been developed to facilitate delivery of evidence-based interventions in non-specialized health-care settings.

Key tips for promoting MH in adolescents and children

- Keep communication constant, open and honest;
- Understand that MH problems are treatable;
- Be attentive to the teenager's behaviour;
- Enhancing social skills, problem solving skills and self-confidence can help prevent MH problems such as conduct disorders, anxiety, depression and eating disorders as well as other risk behaviours including those that are related to sexual behaviour, substance abuse and violent behaviour; and
- Community and school MH promotion programmes for parents, caregivers, teachers and pupils are extremely important.

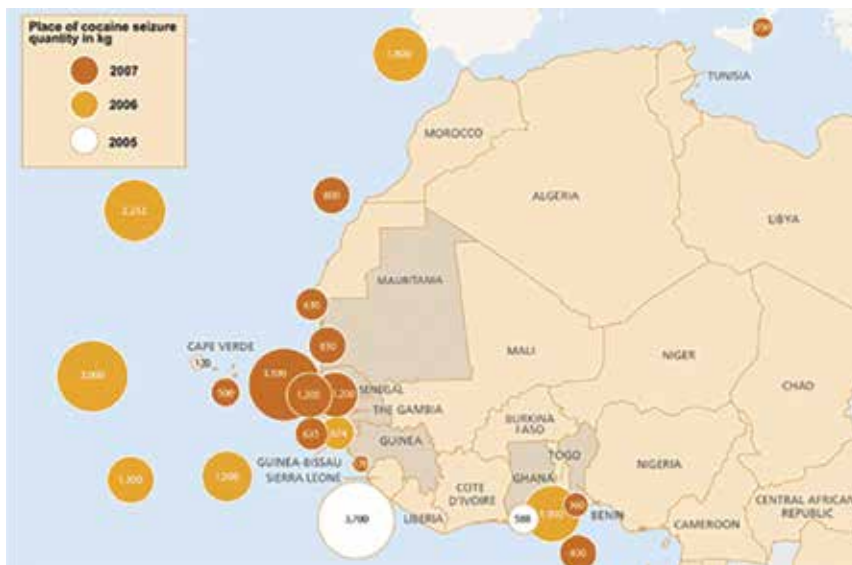
Other related resources are provided in the Resource list in Annexure B.

2.6.3 Substance abuse among adolescents: a public health concern in the African Region

Dr Andrea Bruni, WHO AFRO presented the following discussion on the growing problem of substance abuse in the Region.

The figure on page 61 depicts large (in excess of 100kg) seizures of cocaine on the African continent over the period 2006 and 2007.

Figure 20 Cocaine seizures of more than 100kg in Africa, 2005-2007



Several and varied features characterize substance abuse among adolescents. Therefore users demonstrate no fixed pattern and diagnosis depends on keen observation, vigilance and a healthy index of suspicion on the part of parents and health care workers.

Participation in the use of illicit or harmful substances amongst adolescents spans a broad spectrum ranging from complete abstinence to dependence. The prevalence of substance abuse tends to be higher in out-of-school youth than those who are attending school. Unemployment and accident rates are also higher in users. The financial implications of purchasing drugs can have serious consequences including predisposing users to criminal activities.

Presenting signs and symptoms depend on the users' drug or drugs of choice. Commonly used substances include cannabis (marijuana), stimulants such as cocaine, crack and amphetamines as well as opioids. The effects of these commonly used illicit substances are tabulated in the table below. It is important to note that users might be using single or multiple drugs at the same time so the effects of one substance might be masked.

Table 24 Effects of commonly used illicit substances

SUBSTANCE	EFFECTS
Cannabis	Relaxation Lethargy Anxiety Paranoia Psychosis Schizophrenia.
Stimulants: cocaine, crack and amphetamines	Crack can be smoked, and cocaine powder can be snorted in lines. Both cocaine powder and crack can also be prepared for injecting. Feeling of happiness and being wide awake. Effects are short-lived and are often followed by a "comedown" that makes the user feel depressed and unwell, sometimes for days.
Opioids	Opiates slow down the body's functions and stop both physical and emotional pain. Users find they need to increase doses to get the same effect, or even feel 'normal'. Overdose can lead to coma or even death.

The harmful use of alcohol is a significant public health concern globally as well as in the African Region. Not only does alcohol abuse give rise to acute and chronic health problems, but adverse social consequences are also common. The WHO Global strategy to reduce the harmful use of alcohol includes "Mobilizing communities to prevent the selling of alcohol to, and consumption of alcohol by, under-age drinkers." This is a challenge because "Alcohol is marketed through increasingly sophisticated advertising and promotion techniques, including linking alcohol brands to sports..."

Another strategy is to introduce pricing policies that discourage heavy drinkers and young people. Sierra Leone has taken the initiative and developed a mental health policy with a special focus on youth and substance abuse - The Sierra Leone Mental Health Policy: focus on substance abuse and youths.

An active partnership (WHO-UNODC Partnership) between WHO and the United Nations Office on Drugs and Crime (UNODC) exists in some countries in the Region, notably Benin, Côte d'Ivoire, Mozambique, Senegal, and Togo

WHO has developed intervention guides to assist with integrating the management of substance abuse into primary health care (PHC) settings. The mhGAP intervention guide for mental, neurological, and substance use disorders in non-specialized settings was developed specifically with this in mind.

These and other resources dealing with alcohol and substance abuse are listed on the Resource list in Annexure 1 of this report.



SESSION 3: *Best use of global initiatives to move the country level agenda forward*

An unprecedented momentum is gathering to put adolescent health and development at the centre of global health policies. This provides an opportunity with potential to benefit young people directly, but also to have wide-ranging effects on the health of adults and national economic benefits. In order to accelerate efforts to improve the health of adolescents in the Region, WHO has worked to build and strengthen partnerships, within and outside the UN system, to address issues of shared interest and concern in the areas of adolescent health and development. UN agencies and international organizations have started to build on the collective strengths and comparative advantages in supporting jointly countries across the region.

Examples of new initiatives that provide opportunities to accelerate the movement towards improved adolescent health and wellbeing are indicated in the box below.

New opportunities

- The Global Strategy for Women's, Children's and Adolescent's Health;
- The Global Financing Facility (GFF) in support of Every Woman Every Child;
- The Global Framework for Accelerated Actions for Adolescent Health;
- The new Regional Strategy for Women's, Children's and Adolescents' Health;
- The new five-year adolescent health implementation plan;
- Sustainable Development Goals (SDGs);
- ALL-In Initiative to end AIDS among adolescents
- GAVI Alliance support for HPV vaccination

3.1 AFRO experience in adolescent health regional strategy development and ALL-In initiative implementation

In 2001, the Regional Committee adopted the first five-year Regional Adolescent Health (ADH) Strategy and supported Member States to develop and implement policies, strategies and national standards for AFHS. These focused primarily on SRH and HIV/AIDS. As of October 2014, 32 countries have developed national ADH policies or strategies and 24 countries have developed standards. However, in the 14 years during which the strategy has been implemented, no evaluation has been undertaken.

Why is a new ADH strategy required for the AFRO Region?

Fifteen years after the adoption of the initial ADH Strategy, the situation has evolved and the Region requires a new strategy that responds to these new conditions. These include:

- To equip countries with a reference document to respond to a wider set of health issues facing young people in the region.
- To take into consideration the determinants of health and diseases in young people.
- To start the post 2015 agenda with a new strategy and new orientations in line with the United Nations Secretary General's Global Strategy for Women's, Children's and Adolescents' Health.

The new strategy is structured into seven sections and organised according to the following sequence:

- 1 Overall aims of the Strategy and process of development.
- 2 Guiding concepts and principles.
- 3 Current health status of young people in the African region.
- 4 The determinants of health and disease in young people.
- 5 Challenges and lessons learned from the previous ADH Strategy.
- 6 Core Elements of the Strategy.
- 7 Towards an Operational Plan (Actions by Countries and WHO).

Development of the regional strategy will follow a very consultative and inclusive process. A Select Committee is currently reviewing the first draft of the strategy. Once the Committee's inputs and comments have been incorporated, there will be a Regional Consultation to present and validate the strategy. Adoption by the regional committee is planned in 2016.

3.2 The ALL-In Initiative: Ending the AIDS epidemic in adolescents

ALL-In is a joint UNICEF, WHO, UNAIDS, UNFPA, GF, and PEPFAR initiative to end the AIDS epidemic among adolescents and focuses particularly on excluded groups. The aim of ALL-In is to support countries to conduct country assessments to take stock of progress and identify gaps, bottlenecks and priority actions to accelerate and improve the quality of the national response to HIV among adolescents.

The programme is accelerating results through four work streams:

- 1 Changing the social context by working with adolescents as agents of change;
- 2 Refining the adolescent components of national programmes;
- 3 Promoting innovation and approaches for scale-up; and
- 4 Advocacy, communication and resource mobilization.

ALL-In provides a number of additional benefits in addition to the focus on ending the AIDS epidemic. These include:

- It provides a platform to strengthen partnerships across sectors and foster meaningful involvement of adolescents in all aspects of programming and advocacy for adolescent-appropriate services.
- An opportunity to strengthen and complement adolescent-focused initiatives, investments and resource mobilization efforts e.g. PEPFAR ACT and DREAMS, and national and GFATM funded initiatives for adolescents.
- An opportunity to support countries to improve data collection, analysis and utilization for programme planning and M&E.
- In addition to HIV, the country assessment is also applicable to other programming areas for adolescents.



ALL-IN LEAD COUNTRIES IN SUB-SAHARAN AFRICA (N=18)

- Botswana
- Cameroon
- Cote d'Ivoire
- DRC
- Ethiopia
- Kenya
- Lesotho
- Malawi
- Mozambique
- Namibia
- Nigeria
- Rwanda
- South Africa
- Swaziland
- Tanzania
- Uganda
- Zambia
- Zimbabwe

The assessment process is conducted in three phases that are indicated in the diagram below.

Figure 22 Country assessment process



Using the Swaziland experience as an example, the table below provides the list of indicators that were examined during the country assessment process.

Table 25: Indicators used to conduct country assessment (Swaziland)

INDICATOR TYPE	LIST OF INDICATORS
Demographic	<ul style="list-style-type: none"> Total Population Adolescent population size HIV prevalence Numbers living with HIV New HIV infections AIDS-related deaths
Adolescent key populations	<ul style="list-style-type: none"> Population size estimates HIV prevalence Condom use
HIV prevention, treatment and care	<ul style="list-style-type: none"> Testing ART PMTCT Viral suppression
Combination HIV prevention	<ul style="list-style-type: none"> Condom use Male circumcision Pre-exposure prophylaxis (PreP) Post-exposure prophylaxis (PEP) Harm reduction Cash transfers
Social and programme enablers	<ul style="list-style-type: none"> HIV knowledge Access to media Protective laws and decision-making in health care
Adolescent SRH and other health issues	<ul style="list-style-type: none"> STIs Adolescent pregnancy Family planning Maternal health Iron and folate supplementation TB Mental health, HPV Alcohol use
Gender based violence	<ul style="list-style-type: none"> Child marriage Sexual violence
Social protection	<ul style="list-style-type: none"> Social transfers
Education	<ul style="list-style-type: none"> Girls education SRH education

There are three key considerations for success of the country assessment process. These are:

1 Engagement

- Country engagement to conduct the assessment;
- Partners engagement to support countries; and
- Involvement of all stakeholders as well as adolescents as key actors.

2 Coordination

- Led by government;
- Managed by Technical working groups; and
- Validated by multi-sectoral stakeholders team

3 Indicative Time frame

- 12 weeks including preparation, engagement and reporting; and
- Phase 1 (4 weeks) & Phase 2 (8 weeks).

3.3 Question and Answer Session

Valentina Baltag, Department of Maternal, Newborn, Child and Adolescent Health, WHO HQ facilitated this session.

1 What are the minimum essential health interventions that each country should work on?

Countries should use the following set of criteria to assist with priority setting:

- Scale of the problem e.g. How many people are affected? Is the condition common or rare?
- Health impacts e.g. Does the problem have serious consequences for adolescent health and wellbeing? Is the mortality, morbidity or burden of the disease high?
- Feasibility of implementing solutions e.g. Is support from policy makers likely?
- Likelihood of community support to address the problem.

2 What is new in the Health of the world's adolescents report: A second chance in the second decade?

The report contains new or updated information on the following aspects of adolescent health:

- Explicit focus on the role of the health sector in improving and maintaining the health of adolescents;
- Current thinking about the importance of focusing on adolescent health for public health across the life cycle;
- Visual data on mortality and DALY trends;
- Visual data on prevalence and trends in health behaviour in countries;
- One-stop-shop for WHO guidance incorporating all adolescent-related health issues;
- Global standards for improving health service delivery for adolescents;
- Implications of universal health coverage for adolescents;
- Adolescents' perspectives of their health needs, services and policies;
- Primary care providers' views on addressing adolescents' needs;
- An analysis of the attention paid to adolescents in national health policies and strategies and in mental health policies;
- Pulls together a range of services and interventions that can be provided to adolescents using different platforms, for example health facilities and schools; and
- Synthesizes the work that WHO has

carried out on the development and monitoring of quality standards for health services for adolescents

The document is available at <http://apps.who.int/adolescent/second-decade/>

3 What framework should be used for monitoring adolescent health and development?

The monitoring framework for adolescent health is still not clear. However, the following have been identified as key issues:

- i Core set of indicators to monitor the health status of adolescents nationally and globally can assist countries in facilitating comparable data collection
- ii Range of activities to obtain consensus
- iii Key messages from the Technical Consultation on Health Indicators for Adolescents, held on 30 September - 1 October 2014: **alignment and age disaggregation**

Table 26 Proposed adolescent health indicators

PROPOSED ADOLESCENT HEALTH INDICATORS		
Adolescent mortality rate	Prevalence of intimate partner violence among adolescents	Prevalence of HIV infection among adolescents
Adolescent mortality rate from road traffic injuries	Condom use at most recent sex among adolescents with multiple sexual partnerships in past 12 months	Prevalence of underweight among adolescents
Adolescent mortality rate from HIV/AIDS	Demand for family planning satisfied with modern methods	Prevalence of anaemia among adolescents
Adolescent mortality rate from suicide	Current tobacco use among adolescents	HIV testing among adolescents
Adolescent mortality rate from homicide	Current alcohol use among adolescents	People living with diagnosed HIV infection
Adolescent maternal mortality ratio	Prevalence of insufficient physical activity among adolescents	Antiretroviral therapy (ART) coverage of adolescents
Prevalence of depression among adolescents	Knowledge of HIV transmission among adolescents	New ART patients
Adolescent fertility rate	Parental connection with adolescents	HIV viral load suppression in adolescents
Prevalence of overweight and obesity in adolescents	Health service use by adolescents	Current cannabis use among adolescents
Early initiation of sexual activity	Trained health service providers	
	Parental connection with adolescents	

KEY: Black text = Core indicators Bold text = Additional indicators

The Global framework for accelerated actions for adolescent health will have a monitoring framework.

4 Which steps should be followed to scale up proven evidence-based interventions?

Spontaneous diffusion of innovations from innovative projects and programmes to others is possible. However, successful scaling up almost always requires purposeful action, and needs to be deliberate and guided.

WHO has developed new tools **Beginning with the end in mind: Planning pilot projects and other programmatic research for successful scaling up** and a **Nine-step Guide** and worksheets for developing a scaling up strategy.

These are available at <http://www.expandnet.net/literature.htm>

5 How does one integrate an adolescent health focus into humanitarian interventions?

In order to “Enhance health care in humanitarian settings using health risk assessments and preparedness, gender and rights-based programming and supporting the transition to development” as stated in Strategic action 6 of The Global Strategy for Women’s, Children’s and Adolescents’ Health 2.0, the following activities should be implemented:

- Community health risk mapping/assessment;
- Gender programming;
- Minimum essential package of interventions; and
- Address gaps in the transition between humanitarian response and development assistance.

6 How do you overcome the resistance of hospital managers to create separate YFHS because they are not efficient?

- Don’t “create” separate YFHS! Make existing services adolescent-responsive
- Apply quality standards in every facility
- Global standards for quality health care services for adolescents provide guidance on “what to do”, “how to do”, and “how to measure”

SESSION 4: *Bringing the threads together*

During this final session of the two-day conference delegates weighed the evidence presented, from research findings as well as from the extensive experience that countries in the Region have gathered over several years in terms of implementing adolescent health programmes, to come up with ASRHR priority actions for implementation in their home countries.

The box below summarizes the key areas of focus that are required in order to achieve the ICPD objectives in ASRHR.

What do we need to do to achieve the ICPD objectives in ASRHR?

- We must reach adolescents earlier in their lives than we have; and we must do a much better job of reaching vulnerable and marginalized adolescents;
- We must address ASRHR programmes with a package of “joined up” interventions implemented synergistically at different levels rather than with isolated interventions;
- We must address gender inequalities in terms of beliefs, attitudes and norms and promote more egalitarian power relationships as an integral part of all ASRHR programmes;
- We must move beyond small and short-lived projects to large scale and sustained programmes. This will require both greater investment and attention to the special factors that are critical to scaling up programmes in this sensitive and contentious area;
- We have a rich but still insufficient mix of effective approaches for improving ASRHR; and
- We need research to develop and test interventions and rigorous evaluations of ongoing projects and programmes.



4.1 Feedback in plenary – priority actions identified by countries and consensus statement

After group work in country teams to (1) identify priorities for action and research and (2) propose a consensus statement the groups provided the following list of priority actions to be undertaken in their respective countries.

Table 27 Synthesis of priority actions to improve adolescent SRH in countries

PRIORITY ACTIONS	LIST OF COUNTRIES
Develop or update strategy and/or standards	<ul style="list-style-type: none"> Guinea Bissau Ethiopia Tanzania DRC Zambia
Leadership or Task force	<ul style="list-style-type: none"> DRC
CSE including out of school approaches	<ul style="list-style-type: none"> Guinea Bissau Tanzania Ethiopia Cote d'Ivoire Zimbabwe Rwanda
Training health care providers or comprehensive health education (CHE) – pre-service and in-service	<ul style="list-style-type: none"> Guinea Bissau Tanzania CMR Zambia Zimbabwe
Youth and community engagement	<ul style="list-style-type: none"> Ethiopia Zimbabwe Rwanda
Health Management Information System (HMIS)	<ul style="list-style-type: none"> Zambia
Awareness raising to reduce violence	<ul style="list-style-type: none"> Ethiopia Cameroon
Monitoring and Evaluation (M&E) activities	<ul style="list-style-type: none"> DRC Cameroon
Resource mobilization	<ul style="list-style-type: none"> Cote d'Ivoire
Increase access to services and provide services through outreach	<ul style="list-style-type: none"> Cote d'Ivoire Rwanda

Finally, we congratulate ourselves, the participants, for our availability, attention and interactive participation under the leadership of our facilitators. We hope that on return to our respective countries, we will work to apply the information learned for the health and rights of adolescents. In doing so, at the end of our two days of intense work, we participants:

Commit to:

- 1 Share and apply the information learned to improve our country programmes for sexual and reproductive health of adolescents and youth;
- 2 Maintain our partnership with WHO experts and other UN agencies to enhance coordination and benefit from technical and financial support to achieve the expected results;
- 3 Strengthen, expand, and coordinate evidence-based adolescent health interventions in our respective countries; and
- 4 Prioritize adolescent health on the agenda to improve the lives of African Adolescents.

We recommend:

- 1 The organization of such a sitting at least annually to allow countries to be updated on adolescent and youth health issues; and
- 2 Additional technical assistance should be provided to countries to develop their national strategies as required.

The teams proposed and accepted the following consensus statement:

CONSENSUS STATEMENT

We, the participants, first of all, would like to thank WHO and its partners for taking the initiative to organize this Regional Consultation focused on reviewing progress in the areas of adolescent sexual and reproductive health and rights.

We also thank all the facilitators for the quality of presentations, discussions, clarifications and contributions, in terms of country experiences shared during this Conference.

Our thanks also go to fellow participants, who agreed to be our translators during these two days of interactions. They have played an important role in the success of this consultation. Furthermore, we appreciate the logistical support provided by the secretaries, drivers and other WHO staff and colleagues.

REFERENCES

- AVERT, Worldwide Ages of Consent, Available at www.avert.org/age-of-consent.htm
- Binagwaho et al, Bulletin of the World Health Organization 2012;90:623-628
- Chandra-Mouli V, Mapella E, Theopista J, et al. Standardizing and scaling up quality adolescent friendly health services in Tanzania. *BMC Public Health* (2013) 13:579
- Cook P. 2008 Understanding the effects of adolescent participation in health programmes. *Int'l J Child Rts*, 16 (2008), p.121
- Fonner VA, Armstrong KS, Kennedy CE, O'Reilly KR, Sweat MD (2014) School based sex education and HIV prevention in low and middle income countries : A systematic review and meta-analysis. *PLoS ONE* 9(3) : e89692. Doi :10.1371/journal.pone.009692
- Garcia-Moreno C et al. 2005, WHO multi-country study on women's health and domestic violence against women: Initial results on prevalence, health outcomes and women's responses.
- Gore FM, Bloem PJN, Patton GC, Ferguson J et al. Global burden of disease in young people aged 10-24 years: a systematic analysis. *The Lancet* Volume 377, No. 9783, p2093-2102, 18 June 2011. [http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736\(11\)60512-6.pdf](http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(11)60512-6.pdf)
- Haberland and Rogow (2015) Sexuality education: Emerging trends in evidence and practice. *Journal of Adolescent Health* 56 (2015) S15eS21
- Hainsworth G, Engel MC, Simon C, et al. Scale-up of adolescent contraceptive services: Lessons form a 5-country comparative analysis. *JAIDS Journal of Acquired Immunity Deficiency Syndromes*. 1 July 2014 Vol.66-Issue: p S200-S208 http://journals.lww.com/jaids/_layouts/15/oaks.journals.mobile/articleviewer.aspx?year=2014&issue=07011&article=00008
- IPPF 2012. Participate: The voice of young people in programmes and policies. International Planned Parenthood Federation
- Kaiser Family Foundation 2002. The Global Impact of HIV/AIDS on Youth. <http://www/kff.org/hivaids/upload/The-Tip-of-the-Iceberg-The-Global-Impact-of-HIV-AIDS-on-Youth-Report.pdf>
- Patton GC, Coffey C, Sawyer SM, Viner RM, Haller DM et al. Global patterns of mortality in young people: a systematic analysis of population health data. *Lancet* 2009; 374: 881-92
- Report of the Secretary General, United Nations on 'Assessment of the status of implementation of Programme of Action of the ICPD'; Commission on Population and Development, April 2014. http://icpdbeyond2014.org/uploads/browser/files/icpd_global_review_report.pdf
- Sedge, Singh, Shah and Ahman, 2012. Induced abortion: Incidence and trends worldwide from 1995 to 2008. [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(11\)61786-8/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(11)61786-8/fulltext)
- M. Stoltenborgh, M.H. van Ijzendoorn, E.M. Euser, M.J. Bakermans-Kranenburg A global perspective on child sexual abuse: Meta-analysis of prevalence around the world *Child Maltreatment*, 16 (2) (2011), pp. 79-101 <http://dx.doi.org/10.1177/1077559511403920>
- Tanzania Demographic and Health Survey (TDHS) 2010
- Tanzania Health Management Information System 2012
- UNAIDS Report on the global AIDS epidemic 2013 http://www.unaids.org/sites/default/files/media_asset/UNAIDS_Global_Report_2013_en_1.pdf
- UNESCO 2009. International Technical Guidance on Sexuality Education. <http://unesdoc.unesco.org/images/0018/001832/183281e.pdf>
- UNESCO and UNFPA 2012 Sexuality education: A ten country review of curricula in East and Southern Africa. <http://unesdoc.unesco.org/images/0022/002211/221121e.pdf>
- UNFPA. <http://www.unfpa.org/demographic-dividend>.
- UNFPA 1994. United Nations International Conference on Population and Development. Programme of Action. <http://www.iisd.ca/cairo.html>
- UNICEF 2005. Early Marriage – A harmful traditional practice. A statistical exploration. http://www.unicef.org/gender/files/Early_Marriage_Harmful_Traditional_Practice.pdf
- UNICEF 2011. The State of the World's Children 2011
- UNICEF 2013. Towards an AIDS free generation. Children and AIDS Sixth Stocktaking Report. 2013 http://www.unicef.org/publications/files/Children_and_AIDS_Sixth_Stocktaking_Report_EN.pdf
- UNICEF 2013a. Female Genital Mutilation/ Cutting: A statistical overview and exploration of dynamics of change. 2013.
- UNICEF 2014. A working meeting co-hosted by UNICEF and Columbia University that sought to map out an agenda to dramatically improve MHM in schools over a decade of concentrated, multi-agency, multi-sector coordination. http://www.unicef.org/wash/schools/files/MHM_in_Ten_2014_Meeting_Report.pdf
- United Nations Declaration on the Elimination of Violence against Women. 1993

United Nations Radio. 12 November 2010. "36 000 African women die annually from unsafe abortions".

Upvall, MJ et al. Perspectives of Somali Bantu refugee women living with circumcision in the United States: A focus group approach. *International Journal of Nursing Studies* Vol. 46, Issue 3, 2009.

WHO. Health for the World's Adolescents: A second chance in the second decade. <http://apps.who.int/adolescent/second-decade/>

WHO. No date. Options for linking health interventions for adolescents with HPV vaccination

WHO 2001. RESOLUTION (AFR/RC51/R3) 29 August 2001 ORIGINAL: ENGLISH ADOLESCENT HEALTH: A STRATEGY FOR THE AFRICAN REGION https://extranet.who.int/iris/restricted/bitstream/10665/95733/1/AFR_RC51_R3.pdf

WHO (2008) Adolescent health report.

WHO 2008a. World Health Report 2008 – Primary health care (now more than ever). http://www.who.int/social_determinants/thecommission/countrywork/within/socialparticipation/en/

WHO 2009. Women and health: Today's Evidence, Tomorrow's Agenda. Geneva: World Health Organization.

WHO 2011. 64th World Health Assembly. Youth and health risks. 28 April 2011.

WHO 2013. World Health Organization, London School of Hygiene and Tropical Medicine, South African Medical Research Council: Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva.

WHO 2014. Recommendations on HPV vaccination updated in October 2014. <http://www.who.int/wer/2014/wer8943.pdf?ua=1>

WHO 2015/Special Supplement of the Journal of Adolescent Health (January 2015). *Journal of Adolescent Health* Volume 56, Issue 1, Supplement, Pages A1-A4, S1-S60 (January 2015) International Conference

Zuurmond MA, Geary RS and Ross DA. The effectiveness of youth centers in increasing use of sexual and reproductive health services: A systematic review. *Stud Fam Plann.* 2012 Dec; 43(4):239-54. Doi:10.1111/j.1728-4465.2012.00324.x.

ANNEXURE 1: Resource List

Adolescent and Sexual Reproductive Health Resources

1 Advocacy

- UNFPA (2013) Motherhood in childhood: Facing the challenge of adolescent pregnancy. <http://www.unfpa.org/sites/default/files/pub-pdf/EN-SWOP2013-final.pdf>
- UNESCO (2013) Young people and the law in Asia and the Pacific: A review of laws and policies affecting young people's access to sexual and reproductive health and HIV services. <http://unesdoc.unesco.org/images/0022/002247/224782E.pdf>
- CRR and UNFPA (2010) The right to contraceptive information and services for women and adolescents. <http://www.unfpa.org/sites/default/files/resource-pdf/Contraception.pdf>

2 ASRH Assessment Tools

- WHO (2009) Quality assessment guidebook: A guide to assessing health services for adolescent clients. http://apps.who.int/iris/bitstream/10665/44240/1/9789241598859_eng.pdf
- Pathfinder/AYA (2004) Certification tool for youth friendly services. <http://www.pathfinder.org/publications-tools/pdfs/Certification-Tool-for-Youth-Friendly-Services.pdf>
- Pathfinder/AYA (2002) Clinic assessment for youth friendly services. <http://www.pathfinder.org/publications-tools/pdfs/Clinic-Assessment-of-Youth-Friendly-Services-A-Tool-for-Improving-Reproductive-Health-Services-for-Youth.pdf>
- Population Council (2006) How to conduct a coverage exercise: A rapid assessment tool for programmes and services. <http://www.popcouncil.org/uploads/pdfs/CoverageExerciseGuide.pdf>

3 ASRH Education

- All the puberty books pdf files can be downloaded at <http://www.growandknow.org/books.html>

4 ASRH Humanitarian and Emergency Settings

- Women's Refugee Committee (2012) Adolescent sexual and reproductive health programmes in humanitarian settings: An in-depth look at family planning services. https://www.unfpa.org/sites/default/files/resource-pdf/AAASRH_good_practice_documentation_English_FINAL.pdf
- Save the Children (2009) Adolescent and sexual reproductive health toolkit for humanitarian settings. http://www.unfpa.org/sites/default/files/pub-pdf/UNFPA_ASRHtoolkit_english.pdf
- IASC (2007) Guidelines on mental health and psychosocial support in emergency settings. http://www.who.int/mental_health/emergencies/guidelines_iasc_mental_health_psychosocial_june_2007.pdf
- WHO and UNHCR (2015) mhGAP Humanitarian Intervention Guide: Clinical management of mental, neurological and substance use conditions in humanitarian emergencies. http://apps.who.int/iris/bitstream/10665/162960/1/9789241548922_eng.pdf
- WHO (2013) Building back better: Sustainable mental health care after emergencies. http://apps.who.int/iris/bitstream/am/10665/85377/1/9789241564571_eng.pdf

5 ASRH Policy and Guidance Tools

- WHO (2012) Making health services adolescent friendly: Developing national quality standards for adolescent friendly health services. http://apps.who.int/iris/bitstream/10665/75217/1/9789241503594_eng.pdf?ua=1
- WHO (2011) Preventing early pregnancy and poor reproductive health outcomes among adolescents in developing countries. http://www.who.int/immunization/hpv/target/preventing_early_pregnancy_and_poor_reproductive_outcomes_who_2006.pdf
- WHO (2010) Adolescent job aid. http://apps.who.int/iris/bitstream/10665/44387/1/9789241599962_eng.pdf
- UNFPA (2014) Girlhood, not motherhood! Preventing adolescent pregnancy: A guidance document. http://www.unfpa.org/sites/default/files/pub-pdf/Girlhood_not_motherhood_final_web.pdf
- WHO (2015) Global standards for quality health care services for adolescents: A guide to implement a standards driven approach to improve the quality of health care services for adolescents. Volume 1: Standards and criteria. http://apps.who.int/iris/bitstream/10665/183935/1/9789241549332_vol1_eng.pdf. Volume 2: Implementation guide http://apps.who.int/iris/bitstream/10665/183935/4/9789241549332_vol2_eng.pdf
- WHO (2015) Core competencies in adolescent health and development for primary care providers. http://apps.who.int/iris/bitstream/10665/148354/1/9789241508315_eng.pdf

6 HPV Vaccination

- WHO (2014) Options for linking health interventions for adolescents with HPV vaccination. <http://www.who.int/immunization/diseases/hpv/AdoPlusHPV.pdf?ua=1>

7 Key Young Populations

- UN Interagency Group on Key Populations (2014) Technical Briefs (available online as annexes to WHO consolidated Key Populations Guidelines). <http://www.inpud.net/en/news/technical-briefs-hiv-young-key-populations-young-people-cannot-afford-wait-un-politics>

8 Mental Health and Substance Abuse

- WHO (2010) Global strategy to reduce the harmful use of alcohol. http://www.who.int/substance_abuse/alcstratenglishfinal.pdf?ua=1

9 Special Needs

- WHO (2013) Autism spectrum disorders: From raising awareness to building capacity. http://apps.who.int/iris/bitstream/10665/103312/1/9789241506618_eng.pdf
- WHO (2013) Helping people with developmental disorders. http://apps.who.int/iris/bitstream/10665/110450/1/WHO_MSD_MER_14.1_eng.pdf

10 Violence Against Women

- WHO (2014) Healthcare for women subjected to intimate partner violence or sexual violence: A clinical handbook. http://apps.who.int/iris/bitstream/10665/136101/1/WHO_RHR_14.26_eng.pdf?ua=1
- WHO (2013) Responding to intimate partner violence

and sexual violence against women: WHO clinical and policy guidelines. http://apps.who.int/iris/bitstream/10665/85240/1/9789241548595_eng.pdf

11 Youth Participation

- IPPF (2011) Want to change the world? Here's how. Young people as advocates: Your action for change toolkit. http://www.ippf.org/sites/default/files/web_young_people_as_advocates.pdf
- Rutgers and IPPF (2013) Explore: Toolkit for involving young people as researchers in sexual and reproductive health programmes. <http://www.rutgers.international/our-products/tools/explore>
- IPPF (2012) Keys to youth friendly services: introducing the series. <http://www.ippf.org/resource/Introduction-keys-youth-friendly-services>
- IPPF (2008). Participate: The voice of young people in programmes and policies. www.ippf.org/system/files/inspire_participate.pdf



ANNEXURE 2: Conference Programme

REGIONAL MEETINGS TO TAKE STOCK OF THE PROGRESS MADE IN ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS, IN THE 20 YEARS SINCE THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT, AND ON THE OPPORTUNITIES AND CHALLENGES IN MOVING THE AGENDA FORWARD.

AGENDA

MEETING OBJECTIVES

- To build a shared understanding of the progress made in Adolescent Sexual and Reproductive Health and Rights in the twenty years since the International Conference on Population and Development (ICPD), and on gaps, bottlenecks, opportunities and challenges to be considered in moving the agenda forward.
- To demonstrate how these 5 critical, complementary and interrelated ASRHR intervention areas can be integrated into various policy development activities including National Strategic planning exercise and ongoing/planned evaluations of the National RMNCH Health policies and processes.
- To contribute to better coordinated efforts and evaluate interventions and programme that address adolescent sexual and reproductive health and rights

EXPECTED OUTPUTS

- The key messages distilled from the collection of articles will have been communicated to the participants. Specifically, the need to address adolescents' sexual and reproductive health and rights more effectively, and especially to invest in research in this area will have been communicated to the participants.
- A shared understanding and a shared sense of purpose will have been developed on the progress made, and on the opportunities gaps, bottlenecks, challenges in moving ahead.
- A consensus is reached on the integration of ASRHR into National Strategic planning and planned evaluation of RMNCH interventions and programme;
- The conclusions and recommendations of each meeting will be prepared for publication in appropriate peer-reviewed journals.

PARTICIPANTS

Experts from:

- 1 Ministries of Health;
- 2 United Nations agencies,
- 3 International NGOs,
- 4 Bilateral agencies and foundations
- 5 WHO/HQ/AFRO/ISTs/WCO

TIME	SESSIONS	FACILITATORS
DAY 1 TUESDAY, JULY 7, 2015		
SESSION 1: WORKSHOP OPENING AND INTRODUCTIONS CHAIRPERSON: FRH RAPPOORTEURS:		
8:00 - 9:00	Reception and registration	Secretariat
9:00 - 10:00	Statement by the Regional	Director or DPM
	Self- introduction	Participants
	Administrative announcements	RSUM
	Security briefing	FSO/AFRO
	Overview of the objectives, expected outcomes, agenda and working methods	ADH
	Participants' expectations	Participants
	Group Photo	Participants
SESSION 2: OVERVIEW OF PROGRESS IN ASRH IN THE 20 YEARS SINCE THE ICPD AND THE 15 YEARS OF THE MILLENNIUM DECLARATION CHAIRPERSON: RAPPOORTEURS:		
10:00 - 11:00	Overview of progress in ASRH globally	WHO/HQ
	Overview of progress in ASRH in the African region	WHO/AFRO
	Discussions	Participants
11:00 - 11:30	COFFEE/TEA BREAK	SECRETARIAT
11:30 - 13:00	Plenary presentation by: Discussions	UNICEF, UNFPA, UNAIDS, UNESCO, UN Women
13:00 - 14:00	LUNCH BREAK	SECRETARIAT
SESSION 3: LESSONS LEARNED FROM ASRH AND IMPLEMENTATION IN THE 20 YEARS SINCE THE ICPD CHAIRPERSON: RAPPOORTEURS:		
14:00 - 15:15	Comprehensive sexuality education (CSE): Brief presentation on key message from the journal of adolescent health	WHO/HQ
	Brief prerecorded presentation	UNESCO
	Experience in CSE at the country level	Two countries
	Group work in country team	Participants
15:15- 16:30	Providing adolescent friendly health services (AFHS) and increasing adolescent demand and community support for their provision: Brief presentation on key message from the journal of adolescent health	WHO/HQ
	Brief prerecorded presentation	Pathfinder International
	Experience in AFHS at the country level	Two countries
	Group work in country team	Participants



16:30 – 16:45		COFFEE/TEA BREAK	SECRETARIAT
16:45 - 18:00	Adolescent and Youth participation and leadership: Brief presentation on key message from the journal of adolescent health and AFRO report on the status of adolescent health		WHO/AFRO
	Brief prerecorded presentation		IPPF
	Experience in AFHS at the country level		Two countries
	Group work in country team		Participants
18:00- 18:30	Cocktail		Secretariat
DAY 2 WENESDAY, JULY 8, 2015			
SESSION 3: LESSONS LEARNED FROM ASRH AND IMPLEMENTATION IN THE 20 YEARS SINCE THE ICPD (CONTINUED) CHAIRPERSON: RAPORTEURS:			
8:30 - 9:00		RECAP OF DAY 1	
9:00 – 10:15	Addressing intimate partner and sexual violence among adolescents: Brief presentation on key message from the journal of adolescent health		WHO/HQ
	Brief prerecorded presentation		WHO/HQ
	Experience at the country level		Two countries
	Group work in country team		Participants
10:15 - 10:45		COFFEE/TEA BREAK	SECRETARIAT
10:45 - 12:00	Creating an enabling environment for ASRH: Brief presentation on key message from the journal of adolescent health and AFRO report on the status of adolescent health		WHO/AFRO
	Brief presentation on child marriage (UNICEF) and Female Genital Mutilations (UNFPA)		UNICEF & UNFPA
	Experience in creating enabling environment at the country level		Two countries
	Group work in country team		Participants
12:00-13:15	Promoting adolescent health, beyond sexual and reproductive: Brief presentation based on the Health for the World's Adolescents report		
	Brief presentation on Mental health and substance abuse		WHO/AFRO
	Experience in addressing adolescent health problems beyond sexual and reproductive health		Two countries
	Group work in country team		Participants
13:15- 14:15		LUNCH BREAK	SECRETARIAT
SESSION 4: BEST USE OF GLOBAL INITIATIVE TO MOVE COUNTRY LEVEL AGENDA CHAIRPERSON: RAPORTEURS:			
14:15 - 16:00	Global Strategy for Women's, Children and Adolescent's health		WHO/HQ
	Region Strategy for Women's, Children and Adolescent's health		WHO/AFRO
	ALL In Initiative		UNICEF
	Dream Initiative		WHO/HQ
	African Union Campaign to end child marriage		Africa Union
	Discussions		
16:00 - 16:30		COFFEE/TEA BREAK	SECRETARIAT
SESSION 5: BRINGING THE THREADS TOGETHER CHAIRPERSON: RAPORTEURS:			
16:30 – 17:30	Group work in country team to (1) identify priorities for action and research and (2) propose a consensus statement		Participants
	Feedback in plenary		Participants
	Presentation, discussions on and adoption of a consensus statement.		Participants
17:30 – 18:00	Closing remarks		RD/DPM



ANNEXURE 3: List of workshop participants

NAME	COUNTRY / ORGANIZATION
Dr Afounde Jeannette <i>Bibiche épouse Bang</i>	CAMEROUN
Dr Emah Yakana Irène	CAMEROUN
Dr Guy Michel Mbemba <i>WCO</i>	CONGO
Mr Mbadu Muanda	CONGO, DR
Dr Mbu Bernadette	CONGO, DR
Dr Tano-Bian Aka <i>NPO/WCO</i>	COTE D'IVOIRE
Dr Ourega Marie Paula	COTE D'IVOIRE
Dr Fernandes Alves	GUINEE BISSAU
Dr Mama-Mane	GUINEE BISSAU
Teshome Luwan <i>WCO</i>	ETHIOPIA
Dr Mapela Elizabeth	TANZANIA
Dr Iriya Nemes	TANZANIA
Dr Maria Mugabo <i>WCO</i>	RWANDA
Dr Mary Katepa-Bwalya	ZAMBIA
NPO/CAH	
Ms Mable Mweemba	ZAMBIA
Mr A. Mangombe <i>Adolescents Sexual and Reproductive Health (ASRH)</i>	ZIMBABWE
Dr Tresor Kanyowa	ZIMBABWE
Dr Aloys Kamuragiye <i>WR, UNICEF/Congo</i>	CONGO
Mr Marcel Kabeya <i>UNFPA</i>	DRC
Victoria Kisaakye <i>Programme Specialist in the Eastern and Southern Africa regional office</i>	South Africa
Mr Temitayo Erogbogbo <i>Partnership for PMNCAH</i>	GENEVA
Ms. Molline Marume <i>UN Women</i>	Harare, Zimbabwe
Dr Baltag Valentina	WHO/HQ
Dr Chandra-Mouli Venkatraman	WHO/HQ
DR Sanni Saliyou	IST/CA
Dr Triphonie Nkurunziza	WHO/AFRO
Dr Kasonde Mwinga	WHO/AFRO
Dr Sympllice Mbola Mbassi	WHO/AFRO







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