West African Health Organization

ORIENTATION MANUAL

FOR DEVELOPMENT OF NATIONAL STRATEGIES FOR ADOLESCENT AND YOUTH HEALTH IN ECOWAS MEMBER STATES

USAID
FROM THE AMERICAN PEOPLE

August 2016

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ACRONYMS AND ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante Natal Care
AYH	Adolescent and Youth Health
AYHD	Adolescent and Youth Health and Development
A**YRH**	Adolescent and Youth Reproductive Health
AYSRH	Adolescent and Youth Sexual and Reproductive Health
CSO	Civil Society Organisation
DALY	Disability-Adjusted Life Years
DHS	Demographic Health Survey
ECOWAS	Economic Community of West African States
E2A	Evidence to Action
FGM/E	Female Genital Mutilation/Excision
GDP	Gross Domestic Product
HDI	Human Development Index
HIS	Health Information System
HIV	Human Immune-deficiency Virus
HPV	Human Papilloma Virus
ICCR	International Convention on Children's Rights
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
LMG	Leadership Management & Governance
MDG	Millennium Development Goals
MICS	Multiple Indicators Cluster Survey
MSH	Management Sciences for Heath
NA	Not Available
NCD	Non-Communicable Disease
NGO	Non-Governmental Organisation
PRB	Population Reference Bureau
RH	Reproductive Health
RH/FP	Reproductive Health/Family Planning
SDG	Sustainable Development Goals

SHRP	Strategic Health and Reproduction Plan
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats
UN	United Nations
UNAIDS	United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNESCO	United Nations Education Scientific and Cultural Organization
WAHO	West Africa Health Organisation
WB	World Bank
WHO	World Health Organization

PREFACE

The Economic Community of West African States (ECOWAS) is a geographical zone covering about 5,079,400 km. It was established on 28 May 1975 and constitutes one of the five African Regional Economic Communities. It comprises fifteen (15) member States, which are: Benin, Burkina Faso, Cape Verde, Côte d'Ivoire, The Gambia, Ghana, Guinea, Guinea-Bissau, Liberia, Mali, Niger, Nigeria, Senegal, Sierra Leone and Togo.

In 2014, ECOWAS had an estimated population of three hundred and thirty five million (335,000,000) with an average annual grow the rate of 2.7%, making it one of the highest in the world. More than a third of this population is between 10 to 24 years, giving a total of 100 million young people.. Based on current projections, the the number of young people is expected to increase to 200 million by 2050.

This increasing number of adolecents and youth can be a real opportunity for socio-economic development if appropriate policies and programmes are put in place , taking into account their specific health-related problems and needs

That is why the West African Health Organisation (WAHO), a specialised health instituiton of ECOWAS, developed this manual for countriesto develop or update their national Adolescent and Youth Health/ Sexual and Reproductive Health (AYH/SRH) documents based on evidence-based strategies.

This is consistent with WAHO's mission as defined in the 2016-2020 Strategic Plan, adopted by the 48th Conference of ECOWAS Heads of States in December 2015. Improving the health of maternal, newborn, child, adolescents, youth and the aged. is one of the 13 priority programmes of this strategic plan.

This manual outlines eleven (11) stages for development of national strategies on AYH/SRH. Like any other manual, it will be revised to reflect the realities of the countries in the course of time. It has the advantage of enabling member countries to systematically develop and operationalise their national strategies within their context. We urge countries and our technical and financial partners to use it, and remain open to any contribution that would enrich it further.

Thank you

Dr Xavier CRESPIN
DG WAHO

AKNOWLEDGEMENT

The development of this manual was commissioned by the West African Health Organisation (WAHO). It went through three key phases which are: a situation analysis of adolescent and youth health in the ECOWAS region, the development of a draft of the manual, based on the situation analysis and the validation of the manual during a regional workshop.

This document was produced by WAHO with the support of an external consultant, country representatives, technical and financial partners and a steering committee.

On behalf of WAHO I would like to express my appreciation to everyone who contributed to the development of this manual and commend in particular the immense support provided by the Ministers of Health, WAHO Liaison Officers and Programme Managers/Officers for adolescent and youth health (AYH) in the member states.

WAHO is particularly grateful to USAID West Africa, for its financial support and constant availability . We would also like to thank MSH for its technical support through the LMG Project and Katie CHAU, Principal Youth Advisor of Evidence to Action (E2A) as well as KFW for their valuable contribution.

Dr. Xavier CRESPIN
DG WAHO

INTRODUCTION

Today, there are more young people between 10 and 24 years than ever before. The population of young people is a little less than1.8 billion out of a world population of 7.3 billion. In some regions, particularly in developing countries, not only does the number of young people tend to increase, but also they constitute a larger proportion of the overall population. [1].

In these developing countries, there are several obstacles to the development of young people and the achievement of their full potential. In addition there are high levels of poverty, limited access to basic healthcare, education, potable water, hygiene and basic sanitation with frequent occurrence of conflicts and violence.

This rapid growth in the population of young people in these countries puts pressure on their resources as well as on the capacity of the authorities to meet their needs and to make it possible for them to participate fully in socioeconomic life. The authorities may then consider the growing number of young people as a liability, with additional constraints on the already over-stretched resource. On the other hand, the authoritites may consider young people as a source of new opportunities. With the adoption of investment policies and the participation of young people in the development of their own potential, this high number of young people can then bring to the various nations new producers, inventors, entrepreneurs, agents of change and a mangement class, eqiuipped to resolve the problems that may emerge for the next decades.

The health of adolescent and young people is an essential pillar for attaining the continental and global development objectives, such as recognised in the Joint african position on the post 2015 development programme, in the Agenda 2063 continental development programme “the Africa we want”, as well as in the 2016-2030 global health strategy for women, children and adolescents [2], which aims at supporting the implementation of the Sustainable Development Goals (SDGs).

In some countries the growth rate of the young population especially 10 to 24 years is higher than that of the economy and exceeds the capacity of the institutions responsible for providing this population with basic services. Are the primary and secondary schools and universities well placed to respond to the demand for education? Each year, 120 million young people, attain the age that qualifies them to seek employment. Will there be enough jobs to meet their demand for work and decent renumeration? Are the health facilities adequate to meet their demands? Will young people including adolescents get the needed information and services that are tailored to meet their needs? Will the next generation be capable of enjoying their human rights and achieving their full potential[1]?

1. BACKGROUND AND JUSTIFICATION

The high-frequency of health-related problems among adolescents and young people is due to the fact that their specific health and social needs are not adequately addressed. In order to respond to these needs effectively, many initiatives have been undertaken by countries, including those in the ECOWAS region, with the contribution of development partners, both at the policy and service provision levels. However, an integrated and appropriate response is yet to be proposed and documented to take account effectively of the range of health needs of this sector of the population apart from sexual and reproductive health.

Countries would have to develop and implement appropriate and integrated responses involving all key stakeholders if the range of health issues of adolescent and youth people are to be addressed. It is in this context that WAHO, together with all key partners in adolescent and youth health, including sexual and reproductive health (AYH/SRH) in the region, developed and made available to countries an orientation manual for developing or updating national strategies to offer integrated health services and appropriate responses to adolescents and young people within countries in the ECOWAS region.

The development of this manual is based on the results of the situation analysis conducted in the ECOWAS region.

2. INTRODUCTION TO THE MANUAL

2.1 Objective

This manual mainly aims at harmonizing the procedures for developing or updating national strategies, policies, programmes or plans for AYH/SRH within ECOWAS member countries.

2.2 Content

This manual presents a systematic approach for developing or updating national strategies on adolescent and young people's health. Eleven stages have been outlined for developing or updating the national strategies for integrated health services appropriate to adolescents and young people. These stages have been determined on the basis of an analysis of the process for developing national strategies in member countries.

2.3 Target

This manual aims at helping governments to develop or update national strategies, policies, programmes or strategic plans for AYH/SRH. The principal targets are programme managers or officers of AYH/SRH and in-country stakeholders, as well as national technical and financial partners, non-governmental organisations working with adolescents and youth.

2.4 How to use this manual

This manual can be used as a tool to facilitate the process of developing national documents on AYH, including SRH.

3. CONCEPTUAL FRAMEWORK OF THE DETERMINANTS OF ADOLESCENTS AND YOUTH HEALTH

Figure 1 presents the conceptual framework of the determinants of adolescents and youth health. This framework has been adapted from the 2012 Lancet report series on "Adolescent Health"[3].

This conceptual framework consists of the following determinants which interact in adolescent and youth health :

1 Adolescents and youth in the stages of life
2 social determinants
3 Biology/physiology, puberty and social transitions
4 Psyche and psychology
5 Knowledge, behaviour and lifestyle
6 Morbidity, DALY (Disability-Adjusted Life Year)
7 Country response

- **Importance of health at each stage of life**

Sawyer et al [3, 4] used a conceptual framework to describe a perspective based on the course of life. They highlight the double advantage of investing in adolescents, which are, the preservation of investments made in child health and the promotion of behaviour which will impact positively on adult health. If adolescents attain adulthood in good health by adopting firmly established healthy behaviours, they will have a better chance of becoming healthy and productive adults. Similarly, unsafe or negative behaviour adopted by the youth can have lifelong consequences.

It is estimated that almost 90% of adult smokers started smoking before the age of 20. In the long run, the current health status of adolescents has implications for the next generation because the health of pregnant young girls has a direct impact on the development of their babies.

Besides, adolescent health is not only important for preserving investments in child health and for the promotion of good health in adulthood, but because good health is a human right. Nevertheless, adolescent health has not improved much compared with the health of children. A study of 50 countries has shown that the rate of child mortality has decreased by 80 percent over the last 50 years, while adolescent mortality only improved marginally over the same period.[1] It is important to note that adolescents, especially the girls, are the most vulnerable to health problems, particularly reproductive health.

- **Social determinants of health**

Society and its various institutions, particularly family and school, play a fundamental role in disease prevention and the promotion and management of adolescent and youth health. According to the World Health Organization the social determinants of health are

1 *Susan M Sawyer, Rimo AAfrifir, Linda H Bearinger et al. (2012) "Adolescence, A Foundation for Future Health, "The Lancet, Adolescent Health, April.*

the “circumstances in which individuals are born, grow, live, work, and grow old”. These circumstances depend on the distribution of power, money as well as global, national and local resources [5,6].

Social determinants of health are at two major levels: structural and proximal.

- ***Structural determinants***- the manner in which the society is organised with regard to the social, economic and political contexts can create divisions which lead to differences in status, power, privileges and access to resources and information. Examples include national wealth, income inequalities, levels of education, sexual or gender norms, or ethnicity as well as national laws, policies and regulations [5,6].

- ***Proximal determinants*** are the circumtances of daily life, which directly influence an individual’s attitude and behaviour. Examples of proximal determinants are quality and nature of relations, with family and peers, availability of food and accommodation, opportunities for leisure and the school environment. Since proximal determinants are partially determined by stratifications, resulting from structural determinants, cultural, religious and community factors, they can lead to significant variations in exposure and vulnerability of young people to health-related risks [5,6].

- **Biology/Physiology, Puberty and Social transitions**

  Adolescence is generally defined by chronological age (10 to 19 years) but the patterns of health behavior are more strongly associated with physical changes at puberty. Current research is focusing on the manner in which hormonal changes and other biological changes during puberty influence the development of the brain, the implications for decision-making and the behaviour of adolescents. For example, the part of the brain which governs the desire for reward and pleasure develops earlier than the part which governs self-control, and that can explain increased risk-taking during adolescence. A better understanding of the impact of biological changes and their interactions with social and economic factors will enable an improvement in policies and programmes for young people.

Finally, as emphasised by Sawyer et al [3], puberty is also the beginning of the social transition of the adolescent, who should begin preparing to take up roles in society such as completion of studies, employment, marriage and procreation.

- **Psyche and Psychology**

Social and biological factors act on the psyche and psychology of adolescents and young people and can determine their patterns of behaviour.

- **Knowledge, behaviour, lifestyle**

Knowledge, behavior and lifestyle of adolescents and young people are the immediate determinants of their health status. The behaviour and lifestyle very often result from the interactions with social, biological, psychic and psychological determinants.

- **Country response**

Policies, strategies and interventions implemented by countries ought to take into account the various social, biological, psychic, psychological, behavioural and environmental determinants (physical environment, climatic changes), which are significant in reducing mortality and the burden of morbidity among adolescents and young people

Consequences on health status

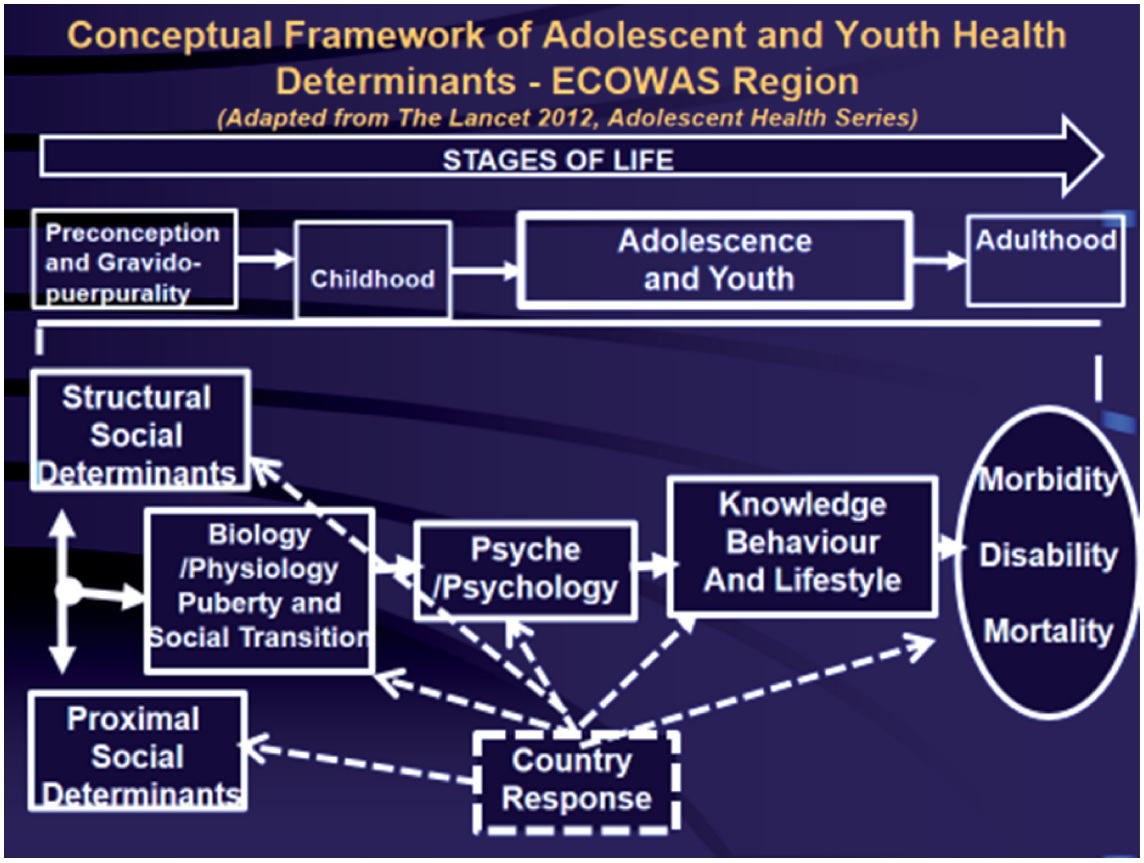
- **Mortality, Morbidity and Disability-Adjusted Years**

Mortality, morbidity and DALYs (Disability-Adjusted Life Years) result from the interaction between various social, biological, psychic, psychological determinants and behaviour patterns. Many forms of risky behaviour patterns and diseases have their root in adolescence and youth.

Adolescence is generally considered as the most healthy period of a person's life. Nevertheless, young people represent an insignificant proportion of the burden of morbidity in the world.

This conceptual framework will serve as a lead for the process of developing or updating national strategies for the provision of integrated health services appropriate for young people.

Figure 1: Conceptual Framework of Adolescents andYouth Health - ECOWASregion (Adaptedfrom Lancet 2012, Adolescent Health Series [3])



4. MAJOR CONCLUSIONS FROM THE SITUATION ANALYSIS OF ADOLESCENTS AND YOUTH HEALTH IN ECOWAS: PRIORITIES AND CHALLENGES

After years of neglect in development plans and by health systems, issues of adolescents and young people's health and development have taken the center stage in countries, as a result the rapid growth in population, their social and health needs in view of their population as well as their role in the development of nations.

This situation analysis, undertaken through literature review and field visits in five countries, has made it possible to account for the various components of the sub-systems of adolescent and youth health in ECOWAS. The major issues identified provide a measure of the existing priorities and health challenges, for both ECOWAS and member countries. This section summarises the issues, priorities and major challenges.

For further details the reader may consult the situation analysis report.

4.1 Status of the determinants of AYH/SRH among adolescents and young people in the ECOWAS region

The current status of the traditional indicators of the health of adolescents and young people within ECOWAS, which are, mortality, morbidity and DALY, is a matter of great concern. Most of the structural and proximal determinants of health are far from optimal.

Knowledge, behaviour patterns and lifestyle of adolescents and young people within ECOWAS countries currently constitute a threat to their health. Indeed, the situation analysis has indicated that most adolescents and young people within ECOWAS countries lack accurate information and therefore adopt behavior patterns and lifestyles that are harmful to good health (unprotected sexual relations, sedentary lifestyle, harmful consumption of alcohol, tobacco and drugs, poor diet and particularly cyber addiction). These behaviour patterns and lifestyles lay the foundation for an epidemic of non-communicable diseases in the coming years.

In view of this situation, the ministries of health, with their strategic and operational partners have rolled out a response, which is however inadequate, but which could or should be improved upon in the coming years. Indeed, in most of the countries there is a real partnership for adolescent and youth health, with a more or less functional coordination mechanism. It has been noted that there is national leadership at the highest level, with legal provisions in favour of adolescents and young people, advocacy and efforts towards resource mobilisation for health, particularly for the sexual health of adolescents and young people. Countries have put in place policies, strategies, directives for adolescent and youth health, with more or less user-friendly interventions and service provision. The availability of data, particularly data disaggregated by age, sex and living environment, still constitute a real weakness in the ECOWAS region. Adolescent and young people's health financing is yet to be improved.

The major strengths identified by strategic and/or operational partners in most countries are: the existence of a framework for consultation and coordination, the availability of a large number of stakeholders, the availability of strategic documents and of youth centers.

The major weaknesses identified by the partners are similar in all the countries visited; they are, in particular: inadequate coordination of partners, unavailability or inadequacy of trained service providers, poor attitude of service providers, overlapping of interventions by various partners, lack of integration of interventions, competition among stakeholders, poor dissemination of strategic documents, lack of research, weak advocacy effort addressed to religious leaders and existience of contradictory legislative and regulatory frameworks.

For most of the existing documents, a sufficient situational analysis has not been done, and aspects such as mental health, the consumption of psychoactive substances, diet, physical exercise, violence, parent-adolescent communication and cyber addiction are not addressed or taken into account, as required.

The problem of adequate involvement of adolescents and young people, as well as stakeholders from the other sectors and the dysfunctioning of existing coordinating mechanisms in the countries is a major concern for partners.

The strategy of youth centers, quite popular in various countries, has more weaknesses than strengths and need to be reviewed in terms of the concept as well as its implementation, in the light of new evidence.

It appears clearly from this analysis that parents also need to be supported to facilitate dialogue between them and their adolescent wards.

Finally, adolescents and young people demand their involvement in decision-making on issues concerning them.

Tables 1 to 3 summarise the health problems, causes of mortality, knowledge and risk behaviour patterns among adolescents and young people within ECOWAS.

Table 1: Health problems among adolescents and young people (ECOWAS)

Major health problems	Examples
1. Sexual and reproductive health, including pregnancy among adolescents	Pre-term deliveries Unintended pregnancies Unsafe abortions Birth and delivery complications
2. Sexually transmitted infections/HIV	Gonorrhoea, Syphilis Increase in the incidence of HIV
3. Poor diet/nutrition	Anemia among women Malnutrition Obesity Consumption of soda
4. Lack of physical activities	Sedentary living
5. Tobacco addiction	Cigarette smo
6. Drug or substance abuse/ addiction	Marijuana, alcohol abuse
7. Mental health	Depression, aggressions, violence, suicide

8. Road traffic accidents	Cars, motorbike accidents
9. Violence	Mob action, bullying
1. Infectious diseases	Diarrhoea Infection of lower respiratory tracts Meningitis
2. Non-communicable Diseases	Asthma, Diabetes
3. Harmful traditional and cultural practices	FGM/FGC, early marriage, etc
4. Gender and sexual based violence	Child abuse, Spousal abuse rape, defilement, etc

Source : WHO [7]

Table 2 : Major causes of mortality among adolescents and young people(ECOWAS)

Pregnancy and delivery complications among adolescents and young girls HIV Motor accidents

Source : Situation analysis of AYH in ECOWAS, WAHO 2016

Table 3: Knowledge, risky behaviour, lifestyle of adolescents and young people in ECOWAS

Knowledge, behaviour and lifestyle	Examples
1. Sexuality and reproduction	• Early sexual debut among adolescents and young people • Unprotected sexual practices • Multiple sexual partners • Limited access to family planning and other sexual and reproductive health services
2. HIV/AIDS	Limited knowledge and unsafe practice in relation to HIV and other sexually transmitted infections, with a remarkable gap between knowledge and prevention
3. Risk factors for non-communicable diseases among adolescents and youth	Tobacco addiction Harmful consumption of alcohol Substance and drug abuse Poor diet and sedentary lifestyle
4. Harmful traditional practices	Early marriages Female genital mutilation/ excisions (FGM/E)
5. Parent-child Communication	Poor parent-child communication on health-related issues particularly sexual and reproductive health

Source : Situation analysis of AYH in ECOWAS, WAHO 2016

4.2 Major priorities, challenges and issues of adolescents and youth health in ECOWAS

4.2.1 Major priorities

On the basis of the results of the situation analysis in ECOWAS, the major priorities to note are:

- **Structural social determinants:**

  - **Education - Improve the quality of teaching and learning,**

Expanding school enrollment especially for the girl child are the driving forces for improving quality of life, developing knowledge and skills as well as future economic growth. Special attention should be given to secondary education as well as higher education, so as to ensure that the skills acquired by the youth are competitive and relevant on the job market [4].

  - **Youth employment - Increase economic opportunities and youth empowerment, especially for girls.**

To develop the skills and capacities of young men and women, more investments are needed to enable them find productive and decent employment. It is also important to reduce the obstacles in job recruitment and professional mobility. Furthermore, it is important to encourage private sector companies to invest in the training of young people and ensure equal access to employment opportunities for them.

  - Creating the enabling environment including enforcement of laws against early marriages and female genital mutilation and formulation of policies promoting the health and development of young people.

  - Improving access to quality and equitable health services for adolescents and young people.

- **Proximal social determinants**

Emphasis should be placed on promoting parent-child communication and the promotion of school health services.

- **Knowledge, behaviour and lifestyle**

Promotion of healthy behaviour and lifestyles through social and behaviour change communication, adolescent and youth-responsive health centres and age-appropriate comprehensive sexuality education. These strategies have proven to reduce the level of misinformation and improve the utilisation of sexual and reproductive health services.

- **Morbidity, Mortality, DALY**

Emphasis should be placed on all the components of AYH including sexual and reproductive health. According to WHO, AYH comprises: nutrition, physical activities, sexual and reproductive health, prevention and management of harmful drug and substance abuse, preventing motor accidents and mental health. The principal measures to consider include:

- promotion of rights to sexual and reproductive health,
- Social and behaviour change communication
- Adolescent and youth-friendly centers for counseling and integrated health services
- Comprehensive Sexuality Education
- Integration of sexual and reproductive health services into STIs and HIV/AIDS services.
- Affordable or free health services particularly for HIV screening and counselling, and circumcision where necessary.
- Appropriate couselling and services including vocational skills for victims of sexual exploitation and abuse, as well as for adolescent commercial sex workers.
- Promotion of HPV vaccination
- Addressing health and social needs of young people with disabilities, vulnerable groups and key populations.
- Build capacity for effective service delivery.

- Strengthen coordination and management of country responses.
- Improve collection, dissemination and utilisation of disaggregated data on adolescents and young people.

4.2.2 Major challenges

The major health challenges would be addressed by ECOWAS countries through WAHO as follows :

1. Positioning of adolescent health as a high priority, with the allocation of adequate financial, human and material resources.
2. The reduction of mortality, DALY and morbidity of adolescents and young people.
3. Identification and implementation of evidence-based interventions taking into account the different levels of health care delivery.
4. Intra and Intersectoral coordination for improving adolescent health and development.
5. Mitigation of threats to social determinants.
6. Enhancing participation of adolescent and young in the designing, planning, implementation and evaluation of programmes for their benefit.
7. Promoting adoption of healthy behaviours and lifestyles by adolescents and young people.
8. Preventing cyber-addiction
9. Establishment of adolescent and youth-friendly health centers.
10. Development of appropriate and competent human resource in AYH/SRH.
11. Definition of specific adolescent and youth health indicators.
12. Promoting the culture of evaluation of AYH/SRH strategies implemented.
13. Provision of data on adolescents and young people (disaggregated data by sex, age and socioeconomic status, etc).

14. Harmonisation of policies, programmes and strategies for the promotion of adolescent health and development.

4.2.3 Major issues

The two major issues to consider are:

- **Investing in adolescents and young people**

Investment in the well-being of young people in sub-Saharan Africa is crucial. Knowing that the current generation of young people has the highest population in history, it is the ideal time to give them the required knowledge, tools and policy environment to adopt healthy attitudes and behavior and improve their capacity to contribute meaningfully to the development of their communities. Young people are living in a period full of physical, psychological and economic changes, as they transit from childhood into adulthood. Supporting young people successfully through this transition period will contribute to breaking the cycle of poverty and will be beneficial to the individuals, communities and nations. It is therefore of utmost urgency to develop appropriate policies and programmes, which take into account specific needs of adolescents and young people. This will further contribute to the attainment of the SDGs and the national development objectives in sub-Saharan Africa.

- **Demographic dividend**

Demographic dividend means rapid economic growth resulting from a decrease in mortality and fertility with an increase in the working age population in relation to the number of young dependents. The decrease in the annual birth rate leads to changes in the distribution of the population by age; the youth who are dependent are fewer in relation to the working age population. The resulting rapid economic growth will be dependent on the development and implementation of appropriate social, economic and investment policies [9].

Policymakers, researchers and other stakeholders discuss the demographic dividend with enthusiasm. The majority of them expect imminent and easily accessible advantages. Nevertheless, many least developed countries will face challenges in achieving this economic advantage if they do not substantially reduce birth rate and infant mortality. While child survival has considerably improved in developing countries, birth rates have remained high in a large number of them. To attain their real economic potential, these countries should act now to increase their commitment and investment in voluntary family planning. [9].

In the absence of higher investments in family planning, many sub-Saharan countries, including those of ECOWAS, are likely to miss the opportunity to accelerate economic growth.

This same point of view is in a recent report of the World Bank (WB) titled “Africa’s Demographic Transition: Dividend or Disaster?”[10]. The authors of this report are of the view that two factors are necessary for the demographic dividend to generate economic growth in Africa. The first consists in accelerating the decrease in fertility, which is currently

slow in many African countries. The second consists in economic policies, which take advantage of the opportunity offered by the demographic trend. While demographic change can induce very productive and good quality labour, this labour must be effectively used and capitalised, in order to harvest the demographic dividends.

5. CHARACTERISTICS OF ADOLESCENT AND YOUTH-FRENDLY INTEGRATED HEALTH SERVICES

The World Health Organization has established five characteristics for adolescent-friendly services. These are:

1. ***Equitable:*** *All adolescents, not only some groups, are capable of obtaining the health services they need.*
2. ***Accessible:*** *Adolescents are able to obtain the services.*
3. ***Acceptable:*** *Health services are provided in a manner that meets the expectations of adolescent clients.*
4. ***Appropriate:*** *Health services needed by adolescents are provided.*
5. ***Efficient:*** *Good health services are provided in the right manner and make a positive contribution to adolescent health.*

It is important that services are integrated to ensure that adolescents and young people get all the services they need at the same place.

These characteristics are based on the following Pillars :

1. Policies appropriate to adolescents and young people which:

- respect the rights of adolescents, as indicated in the United Nations convention on the rights of the child as well as in other instruments and declarations,
- take into account the special needs of the various groups of the population, including the vulnerable and deprived, which do not limit health service provision simply due to problems related to sex, disability, ethnicity, residence, relationship or age (unless that is strictly appropriate),
- pay special attention to gender issues and norms,
- guarantee privacy and promote autonomy, so that adolescents can give consent for their own healthcare.
- guarantee that services are free or affordable for adolescents.

2. Adolescent and youth-friendly procedures which provide:

- easy and confidential registration of clients as well as easy retrieval and archiving of folders
- short waiting times and (if necessary) prompt referral to another facility,
- consultation with or without appointment.

3. Adolescent and youth-friendly health service providers, who:

- are technically competent in areas that are specific to adolescents, and who provide health information and services tailored to meet the peculiar needs of adolescents and young people
- have good interpersonal and communication skills,
- are motivated and supported,

- not biased and judgemental
- approachable and trustworthy,
- devote sufficient time to clients,
- act in the best interest of their clients,
- treat all clients with equal attention and respect

4. Adolescent-friendly support staff who are:

- understanding and attentive, and treat each adolescent client with equal attention and respect,
- competent, motivated and well supported.

5. Adolescent-friendly health facilities which:

- provide a safe environment with a pleasant ambience, and easily accessible.
- have convenient opening hours,
- guarantee privacy and avoid stigmatisation,
- provide information education and communication (IEC) materials.

6. Participation of adolescents so that they are:

- well informed about the services and their rights
- encouraged to respect the rights of others,
- involved in the design, provision and evaluation of services.

7. Community participation and dialogue, in order to:

- promote the value of health services,
- encourage parental support and that of the community.

8. Community and local services, in order to increase coverage and accessibility.

9. Comprehensive services which

- meet the health, social, psychological and developmental of adolescents and young people,
- to provide comprehensive package of healthcare as well as prompt referrals to the next level of healthcare when needed,

10. Efficient health services for adolescents which:

- are guided by standards and protocols
- have basic equipment, supplies and services required for the provision of essential healthcare,
- have a process for improving quality, creativity and motivation of staff.

11. Efficient Health Management Information System which has

- information on costs of resources needed for effective health service delivery,
- system for using this information to improve service delivery.

12. Integrated services

- adolescents and young people are able to access all services they need at the same place.

13. Multisectoral response

- An effective commitment by the sectors of education, youth, interior and social protection to ensure availability of complementary services.

6. GENERAL OVERVIEW OF THE STAGES IN DEVELOPING OR UPDATING NATIONAL STRATEGIES FOR ADOLESCENTS AND YOUTH INTEGRATED HEALTH SERVICE DELIVERY

Eleven (11) stages have been adopted for developing or updating national strategies for the provision of adolescents and youth integrated health services. These stages have been determined on the basis of an analysis of the process for developing national strategies in member countries. The table below presents a general overview of the eleven (11) stages.

Table 4: General overview of the 11 stages in developing national AYH/SRH Strategies

Stages	Title	Description
1	Identification, inventory and consultation with all AYH/SRH stakeholders and the establishment of a team to steer the process	Identification, inventory, consultation among stakeholders and establishment of a steering committee and a technical team
2	Preparing and conducting the situation analysis	Planning, preparing and conducting the situation analysis by the technical team
3	Analysis of results and identification of priorities including the principal priority targets: SWOTanalysis	Utilisation of the SWOT analysis approach to identify the strengths, weaknesses, opportunities and threats within each group of determinants
4	Basis for formulating strategic objectives of the strategy paper	Formulation of the strategic vision and objectives
5	Definition of guiding principles for the provision of integrated health services appropriate to adolescence and youth	Definition of the guiding principles which should constitute the framework and guide for the required services for adolescents and youth
6	Choice of strategies and interventions	Choice of promising or tested strategies/ interventions
7	Definition of the institutional framework for implementation	Definition and explanation of all factors which at the same time ensure legality, regularity and continuity or sustainability of activities to be undertaken
8	Selection of indicators and development of the monitoring and evaluation framework in collaboration with the national health information system	Selection of indicators and development of the monitoring and evaluation framework for implementing the strategies in order to monitor and measure the changes for purposes of correction or adjustment, if necessary.
9	Drafting of the document	Drafting of the document taking into account the local (national) context and the results of the analysis and consultations or collaborations undertaken
10	Validation of the document	Validation of the document together with all key stakeholders
11	Publication of the document	Dissemination of the document to the targets and principal users.

7. DETAILED DESCRIPTION OF THE STAGES

STAGE 1: Identification, inventory and consultation with all AYH/SRH stakeholders and establishment of a steering committee

The principal mission of the ministries of health is to provide leadership for the country's health system. According to WHO global health Report 2000, [12], the health system comprises all organisations, institutions and resources leading to the implementation of measures whose principal objective is to improve health. This broad definition includes, but goes beyond, the direct responsibilities of a Ministry of health. However, the latter being the principal stakeholder, should assume the responsibility for leadership and governnance. Since adolescent and youth health constitutes a sub-system of the health system, it's improvement depends on its leadership and its capacity to assume some major functions including intra- and intersectoral collaboration and coordination.

National strategies further have the possibility of being efficiently implemented if all AYH/SRH stakeholders participate in their development and determination. This means it is appropriate to ensure the participation of all stakeholders, following broad consultations, constructive political dialogue, in order to arrive at a consensus on the current situation, and on the values, objectives and general policy orientation from which the health policy for this age group will draw inspiration.

As demonstrated in the conceptual framework, resolving the health problems of adolescents and youth requires a multisectoral, intersectoral and intrasectoral approach. Four major activities should be accomplished during this stage: 1) identification of stakeholders, 2) establishment of a list of stakeholders, 3) consultation among stakeholders and 4) establishment of a steering committee to guide the process of developing the strategy document.

1.1 Identification of stakeholders

It is important for the Ministry of health, which assumes leadership in matters of adolescent and youth health to have a complete list of stakeholders working in the area of AYH/SRH in the country and at all levels of the health system in the country. This is not only about strategic partners, but also about all partners involved in implemention.Various techniques can be utilised to identify the stakeholders : snowball technique, invitation through the media, etc.

1.2 Inventory of stakeholders

Establishing a directory of all AYH/SRH stakeholders with all the information comprising areas of intervention, location of intervention and specific targets where necessary. The goal of this stage is to have a mapping or directory of all stakeholders engaged in AYH/SRH in the countries, including those who have power, responsibility and rights in the matter.

Even though they may differ from country to country, the major AYH/SRH stakeholders shall include, in particular:

- The Ministry of Health
- The Ministry of youth
- The Ministry of Education
- Ministries involved in youth programmes (Ministry of Culture, Sports Ministry, Ministry of Employment)
- Organisations of adolescents and youth
- Organisations of parents of adolescents and youth
- Professional associations of health service providers
- Professional teachers associations
- United Nations Agencies
- Bilateral institutions
- International NGOs
- National NGOs
- Private Sector (profit-making)
- Academic institutions
- Informal training centers
- Civil Society Organisations (non-profit, Community Based Organisations, Community Based Groups)
- Traditional Institutions
- Faith Based Institutions.

1.3 Stakeholder Consultations

Organise broad consultations among all key stakeholders in AYH/SRH. This may require an assembly of stakeholders forum. The appropriate format will certainly vary from country to country in view of the organisations already existing and the country perculiarities.

This consultation will enable stakeholders share information, have discussions and establish consensus on the real health problems of adolescents and young people in the country and also prepare the ground for developing strategies.

1.4 Establishment of a steering committee and a technical committee

The last activity of this stage is the establishment by consensus of the steering committee and the technical committee. The steering committee shall be politically responsible for validating the key stages in the preparation of the document, while the technical committee shall undertake the entire process under the supervision of the steering committee. The technical committee shall be a small multidisciplinary team with a maximum of 9 to 11 members with specific terms of reference. This team can be supported by consultants. The steering committee shall be composed of national directors of the various sectors involved in AYH/SRH in the country.

The composition of the technical committee can vary from country to country, but it should comprise at least a public health specialist with expertise in adolescent and youth health, a socio-anthropologist, a demographer, a health economist, a bio-statistician and a communication specialist.

Final outcomes of stage 1	- Directory / Mapping of stakeholders - Stakeholders consultative report - Establishment of a steering committee and a technical team with clearly defined terms of reference

STAGE 2: Preparing and undertaking the situation analysis

An analysis of the health situation is fundamental for designing and updating national health policies, strategies and plans for adolescents and young people.

A comprehensive situation analysis is not limited to a simple collection of facts describing the epidemiology, demography and the health status of the population. It should be complete, covering the entire set of current health issues and potential future issues as well as their determinants. It should also assess the current situation in relation to expectations and needs of the country[13].

A situation analysis can also then serve as the basis for defining the priorities that should attract interest within the framework of health policies, strategies or plans, subject to a broad policy and participatory dialogue [13].

The preparation and conduct of the situation analysis is one of the tasks of the technical team under the supervision of the steering committee and supported by consultants if necessary. The situation analysis is presented as follows:

2.1 General objectives

Taking the conceptual framework as a reference we can deduce that the objective of the health situation analysis of adolescents and youth would be: to analyse the health status and major determinants of adolescents and youth health, with the view to designing policies, strategies and programmes that are relevant to AYH or to update these documents when necessary. The analysis should also provide a summary of the current national response including the results and challenges faced during the implementation of AYH programmes and policies in the past.

2.2 Specific objectives

Depending on the context and policy choice of the country, the specific objectives can target a number of determinants. However, it would be ideal to target the maximum number of determinants in order to have a better assessment of the health situation of adolescents and young people.

Figure 2 presents the possible issues that could be targeted by the specific objectives.

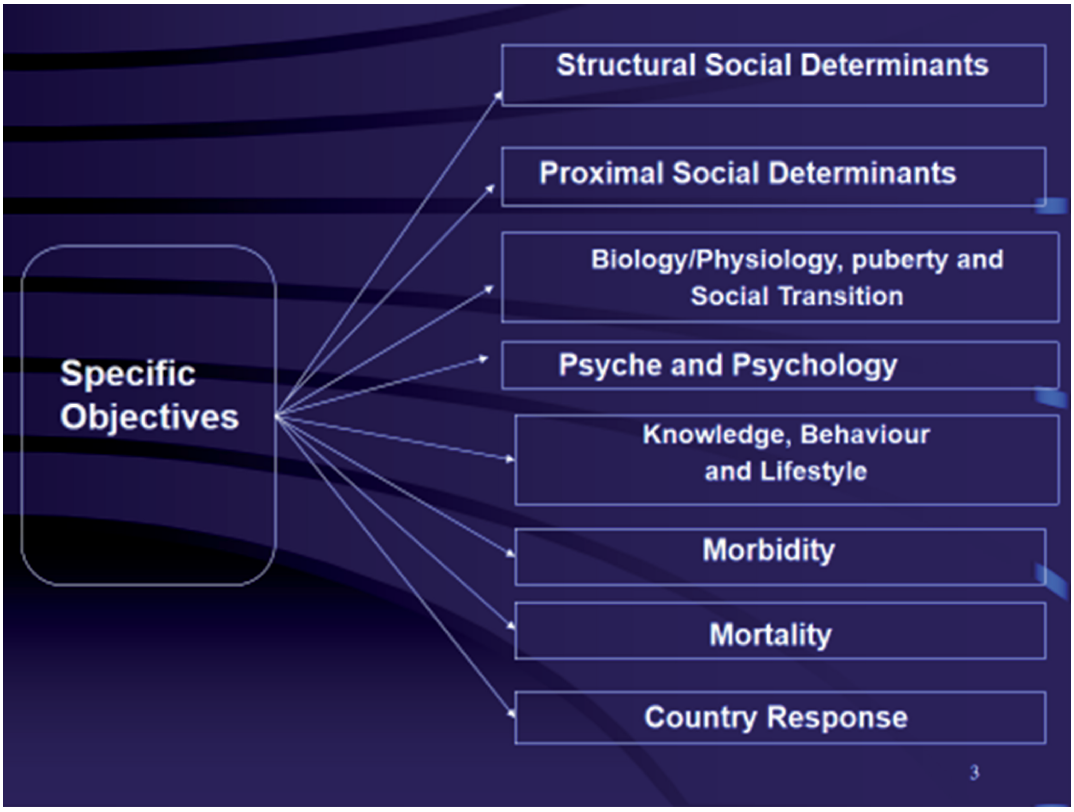


Figure 2: Possible choice of specific objectives of the situation analysis

2.3 Information to be collected

Referring to the conceptual framework, the categories of determinants presented in table 5 provide a summary of the critical information to be collected during the situation analysis. For each of the categories and sub-categories of determinants, the team should prepare a clear and precise list of key indicators whose current validity should enable the determination of adolescent and youth health status in the country. A short indicative list can be found in stage eight (8).

Table 5: information to be collected during the situation analysis

No	Health status and determinants	Information to be collected
1	Structural social determinants	1. Demography of adolescents and young people 2. Economic data of the country including the level of poverty 3. Health system (human and financial resources, infrastructure, performance (supply of services/ benefits, utilisation of the services, Quality of the services and the perception of the youth regarding the services), health information, medicines and technologies, governance 4. Education (rate of school enrollment and continued schooling for girls and boys in the primary, secondary schools and at the University) 5. Youth employment 6. Physical environment 7. Cultural context 8. Equity in health (what types of youth are the most vulnerable to health problems and what is their level of access to the health system, the mechanisms in place to facilitate this access)
2	Proximal social determinants	1. Characteristics of the family environment of adolescents and youth 2. Characteristics of the school and university environment of adolescents and youth
3	Biology/Physiology, puberty and social transition	Management of puberty and social transition in the country Socio-anthropological data on puberty management
4	Psyche and Psychology	Psyche and Psychology of adolescents and youth Data on the psychology of adolescents and youth in the country
5	Knowledge, behavior and lifestyle	1. Knowledge on health /AYH/SRH 2. Risky behavior and lifestyle.Safe behavior and lifestyle 3. Adequacy of the content of pre-service curriculum as one of the information to be collected 4. (See the content in table 7)
6	Morbidity	Major health problems of adolescents and youth Demographic and Health Survey Reports of Global AIDS Response Progress Reporting (GARPR) UNICEF[2] country statistics on adolescents (see indicators proposed by WHO for adolescent health[3]) (See content in table 6)

7	Mortality	Major causes of mortality among adolescents and youth Demographic and health surveys Reports of Global AIDS Response Progress Reporting (GARPR) UNICEF[4] country statistics on adolescents (see indicators proposed by WHO for adolescent health[5]) (See the content in table 6)
8	Country responses	Stakeholders: partnership and cordination for adolescents and youth health Rights/advocacy/national leadership/coordination/ resource mobilisation Health policies, strategies and directives for adolescents and youth Interventions and provision of services to adolescents and youth (utilisation of services, quality of the services youth perception of the services) types of points of service available and accessible to adolescents and youth, how many health facilities are accessible to adolescents/youth and where are the health facilities located) School health Financing Monitoring and Evaluation, Research Health information system Lessons learned, challenges and measures taken to meet the needs of adolescents and youth.

2.4 Data collection methods

Various methods can be used to collect the expected data or information. These methods depend on the type and source of information to be collected as well as on the time and budget allocated for the analysis. A combination of quantitative and qualitative methods would be useful for collecting information on adolescent and youth health. The following techniques and tools can be given priority:

1. Literature review of the major studies undertaken in the country and elsewhere (in the region and beyond) on adolescents and young people.

Before undertaking the collection of quantitative and qualitative data, it is indispensable to undertake a literature review. The technical committee should collect recent data on

2 *UNICEF. Information by country and programme.http://www.unicef.org/infobycountry/*
3 *OMS.Proposed Health Indicators for Adolescents (ages 10-19 years). http://apps.who.int/adolescent/second-decade/section/section_7/level7_1.php*
4 *UNICEF. Information by country and programme.http://www.unicef.org/infobycountry/*
5 *OMS, Proposed Health Indicators for Adolescents (ages 10-19 years). http://apps.who.int/adolescent/second-decade/section/section_7/level7_1.php*

AYH (including DHS data, reports on AYH programmes and projects, papers published in academic journals, etc.). After analysing existing data, the technical committee could identify the gaps and plan a data collection exercise to cover the gaps.

2. Questionnaire to be administered to the Ministry of health and other ministries
3. Semi structured interviews with sample stakeholders so as to better determine the perspectives and positions of stakeholders
4. Focus group discussions with youth and other stakeholders involved in AYH (eg. parents, health service providers, teachers, etc.)

2.5 Data collection tools

Appropriate data collection tools should be developed or adapted from existing tools, then tested. Table 6 presents a few examples of tools to be developed. Annex 3 presents a few tools that could be adapted by countries. But other tools that are appropriate to their specific needs could also be developed.

Table 6 : Data collection tools

Questionnaires/ Interview Guide	Targets
Tool 1: Country response questionnaire	Ministries of health and other relevant/ appropriate Ministries having responsibilities and authority
Tool 2 : Interview guide with Adolescents and Youth Health stakeholders in the country	AYH stakeholders
Tool 3 : Group interview guide with adolescents and youth associations	Adolescents and youth as persons having rights and responsibilities
Tool 4 : Interview guide with the Association of parents of adolescents and youth	Parents/keepers of adolescents and youthas persons with responsibilities
Tool 5 : Interview guide with officials of adolescents and youth health facilities	Officials of health facilities aspersons having responsibilities and authority
Tool 6 : Major health indicators including AYH indicators	Ministry of health and other relevant/ appropriate Ministries

2.6. Report of the situation analysis

The situation analysis report is the final result of this stage. The plan for this report could vary from country to country depending on the coverage envisaged by each country. However, it should contain the major critical issues for the development of the strategic document.

Final outcomes of stage 2	- Summary of the literature review - Data collection tools - Situation analysis and report

STAGE 3: Results analysis and identification of priorities, including the major priority targets: SWOT

This stage could be combined with the preceding stage since it constitutes the goal of the situation analysis. However it is recommended that it is undertaken as a separate stage with a larger audience to benefit from the contributions of a larger number of stakeholders. The results of this stage will be incorporated into the report of the situation analysis. Besides, this stage can bring together members of the technical team, members of the steering committee and other resource persons who are members of the assembly of stakeholders.

One of the recommended tools for this stage is the Strengths, Weaknesses, Opportunities and Threats (SWOT) tool.[6] The SWOT tool is very much appreciated by analysts since it serves a double purpose:

1. Internal analysis of the determinants, organisations or stakeholders engaged in AYH/SRH.
2. External analysis of the determinants, organisations or stakeholders engaged in AYH/SRH.

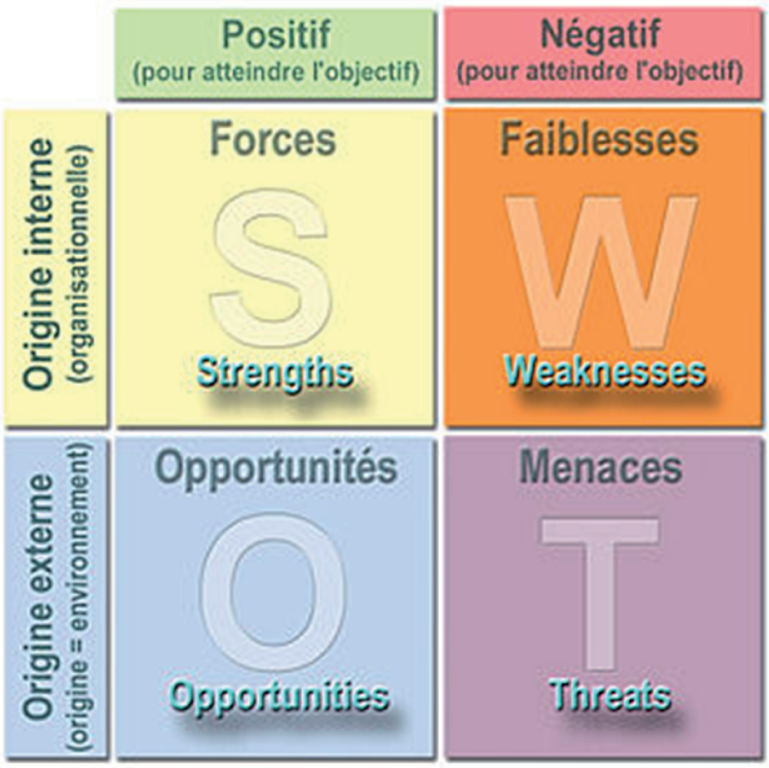
The SWOT tool (analysis + matrix) is likely to be used very broadly in many areas to analyse, diagnose and describe:

- A current status - a situation, an environment
- The diagnostics of operational dynamics - a process, a project
- The assessment of a desire and its effects - a policy, strategy

The SWOT tool is also valued by policy makers since it produces a perfect summary (general, specific and prioritised) of the factors to be taken into account for making a “good” decision.

6 *[The termSWOT, used in the expressionSWOT analysis orSWOT matrix is an acronym is derived from English forStrengths (forces), Weaknesses (faiblesses), Opportunities (opportunités), Threats (menaces) [14].*

Figure 3 below presents the SWOT matrix.



This stage will enable a review of the status of each of the categories of determinants and each of the component factors.

Below are some questions which should be analysed in order to prioritise:

- What are the major health problems or issues including sexual and reproductive health (SRH) among adolescents and young people of both sexes in the country?
- What is the impact of these problems from the health, social and economic points of view?
- Which youth sub-groups are the most affected by these issues?
- What are the strengths and weaknesses of the health system in addressing these problems? - What are the current or future opportunities?
- What are the health regulations, policies and directives which influence AYH?

At the end of this stage, a summary of the highlights and priorities shall be prepared and integrated into the report of the situation analysis and into the strategic document.

Final outcome of stage 3	Summary of the key issues (SWOT) and the priorities to be incorporated into the situation analysis report and into the strategic document.

STAGE 4 : Formulating the vision and strategic objectives of the national AYH strategic document.

4.1 Vision

The vision should reflect the aspirations of the country with regard to adolescent and youth health. The formulation of the vision can vary, depending on the country. However it should show clearly the future ambition of the country for the health of adolescents and young people. Two examples of visions which, though formulated differently, show the extent to which the authorities of the respective countries want to respond to AYH. Though these two visions focus on SRH, it is important to go beyond SRH.

Examples of visions formulated by some countries of the ECOWAS region

- **Benin**

"The vision of stakeholders in AYRH/HIV/AIDS, that is, Directors of sector ministries, NGOs engaged in AYRH/HIV/AIDS, leaders of youth organisations and technical and financial partners is: **« a beninese society where all adolescents and youth of 10 to 24 years enjoy their rights and fulfill their responsibilities in sexual and reproductive health and benefit from good healthcare, in line with their specific SRH/**STI/HIV/AIDS needs" [15].

- **Senegal**

"all adolescents and youth in Senegal, without any distinction or discrimination, shall participate in and have universal and equitable access to evidence-based quality sexual and reproductive health services. These services shall be delivered to all segments of the community of adolescents and youth through the use of relevant approaches and technologies with due respect to the cultural values and beliefs of the country"[16].

4.2 Goal

The goal summarises more specifically how the strategy shall contribute to the vision. The expectation of the goal will depend on the implementation of the strategy, but also on other relevant strategies.

In view of the demographic significance of adolescents and youth and their specific needs, it is important for the country to lay the foundation towards ensuring demographic dividends. In this regard, the aim of the strategic document should take into account not only health, but also the development of adolescents and young people

The goal of this strategic document would be to contribute to making the health and development of adolescents and young people a national priority

Examples of goals formulated by some ECOWAS countries

- **Benin**

"Contribute towards improving the life of adolescents and youth in Benin, with a view to achieving the MDG's" [15].

- **Nigeria**

"The goal of this strategic framework is to facilitate the implementation of National Adolescent Health Policy that aims to improve the quality of life of young persons in Nigeria" [17].

- **Senegal**

"The goal of the adolescent and the youth sexual and reproductive health plan is to contribute to the health and well-being of adolescents and youth of 10-24 years living in Senegal through the supply of appropriate and efficient services" [16].

- **Sierra-Leone**

"To contribute to the improvement of the status of adolescents and youth health through the implementation of interventions aimed at the major health problems" [18]

4.3 General objective

The general objective states the purpose of the strategy. In this document, the general objective would be to promote the health and development of adolescents and young people in the country.

Examples of general objectives formulated by some ECOWAS countries

- **Benin**

1. "Improve the institutional, socio-cultural and policy environment for the development of RHAY/STI/HIV activities"
2. "Improve the level of knowledge and skills of adolescence and youth in RHAY/STI/HIV/AIDS"
3. "Improve the availability and accessibility of quality RHAY/HIV/AIDS services in order to ensure higher patronage by adolescents and youth" [15].

- **Senegal**

"Promote the sexual and reproductive health of adolescence and youth"[16].

4.4 Specific objectives

The formulation of the specific objectives of this strategic document should be based on the determinants of adolescent and young people'shealth, as has been the case with the specific objectives of the situation analysis. The specific objectives indicate precisely what immediate results the strategy is expected to produce.

The specific objectives should be "SMART":

- Specific: clearly formulated (without ambiguity),
- Measurable: (quantifiable by use of available tools and methods),
- Acceptable: Acceptable by all stakeholders
- Realistic: should be achievable, should be implementable or be ammenable to adjustments if the context changes;
- Time bound: should fall within a timeframe with an end date, and possibly with intermediate stages.

Final outcome of stage 4	- Definition of the vision, goal, general objective and the specific objectives of the strategic document.

STAGE 5: Definition of the guiding principles for the provision of adolescent and youth-friendly integrated health services

Any national AYH/SRH strategy ought to be guided by principles which will contribute to its success. The following recommendations are not exhaustive but they contain the guiding principles recognised worldwide as being important for national AYH/SRH strategies:

- **Rights-based approach**: Health constitutes a fundamental human right recognised by international legal instruments ratified by ECOWAS countries (such as, the International Convention on the Rights of the Child, and the African Charter on Human and Peoples Rights) and enshrined in the constitution of member countries.
- **Ownership by the state and by all stakeholders**: ownership of the national strategies both by government and by non-State actors, is essential to ensure the effective, efficient and sustainable implementation of the strategies. The best way to ensure ownership by stakeholders is to involve them throughout the process of planning, development, implementation and evaluation. Besides, each stakeholder should have one or more responsibilities clearly defined in the process and is expected to have a real interest in the subject-matter of the strategy.
- **Multisectoral approach**: the development of the strategic document should be guided by a multisectoral approach in order to strengthen the linkages between the health sector and other sectors that have important roles to play in the implementation and to guarantee an environment and conditions that are favorable to AYH. Such an approach should take advantage of the respective strengths and leverage on existing platforms of the various stakeholders providing services to adolescents and young people to increase demand and access. In concrete terms, the steering committee and the technical committee should have representatives of the various sectors, in order to ensure multisectorality throughout the process.
- **Partnership, coordination and harmonisation:** intervention approaches at all levels, both within and outside the health sector, lead to the establishment of an

efficient system, which avoids duplication but also maximises resources with a synergy of activities to achieve better impact.

- **Involvement and empowerment of adolescents and young people: ("what is done for the youth, without the youth, is against the youth").** The involvement of adolescent and youth is recognised as a human right, through several international declarations, such as the international convention on the rights of the child (ICRC), the CIPD action programme and the commitment declaration on HIV/AIDS (UNGASS decalration on HIV/AIDS of 2001). Several factors justify the active participation of adolescents and young people in the development of national AYH/SRH strategies. Since adolescents and young people are experts in their own experience, their participation can ensure that the strategies respond to their real and varied needs. Besides, a lot of youth in the ECOWAS region are involved in youth associations and movements, which are working towards the improvement of the living conditions of life in their countries. In this regard, the young people have the relevant experience to contribute to the development of national strategies in their capacity as active citizens and agents of change. Their participation in the development of strategies facilitates ownership and that has a significant impact on the implementation and success of the strategies. Adolescents and young people constitute heterogenous groups.Therefore, engagement of young people in the development process should be through youth associations and groups which have a diversity of membership.

- **Evidence-based strategies:** The choice of strategies/ interventions to be included in the document should be substantiated with data and should take into account emerging issues in AYH. Evaluating the quality, efficiency and effectiveness of strategies is very important for informed decision-making towards achieving expected health results.

- **Promotion of equity and gender**: Today, it is recognised that sustainable development, poverty reduction, improvement in health, cannot be achieved without eliminating, gender and social inequalities and addressing the needs of adolescent with disabilities. There are significant differences between the causes of mortality and morbidity among adolescents and young people. Furthermore, inequality between the sexes is a significant determinant of the health problems of young people, particularly among female adolescents and young women. Meanwhile, access to basic health services is inequitable between the rich and the poor. It is therefore necessary for national AYH/SRH strategies to take into account the issues of various groups in the young population.

Final outcome of stage 5	- Definition of the guiding principles

STAGE 6: Choice of strategies and interventions

In this document, the operational definition of the term strategy or intervention is the entire broad outline of activities that are likely to positively influence the determinants of AYH/SRH towards better health, growth and development of adolescents and young people in the country. The improvement of health and the development of this group require measures that are efficient, sustained and coordinated by stakeholders at all levels of the health system and other related sectors.

Adolescents and young people's health represents a complex interaction of determinants which a country should take into account in the development of its strategic document. From the results of the AYH/SRH situation analysis, we considered some interrelated determinants, which have been discussed earlier in this document.

In choosing strategies for improvement of the health and development of young people, the following questions should be address:

1. How do we positively influence the structural social determinants for the well-being of adolescents and youth?
2. How do we positively influence the proximal social determinants for the well-being of adolescents and young people?
3. How do we help adolescents and young people to go through puberty and social transition smoothly, without anguish?
4. How do we help the young people overcome psychic and psychological tensions, which characterise puberty and social transition?
5. How do we improve the knowledge, behaviour and lifestyle of adolescents and young people in an era where the media and social media tend to take over the role of parents?
6. How do we get parents to establish effective dialogue with their children?
7. How do we reduce health risks and problems among adolescents and young people?
8. How do we reduce maternal mortality and HIV complications among adolescents and young people?
9. How do we improve the efficiency and quality of country response to the issues confronting adolescents and young people ?

It must be recognised that none of these questions has a simple response. Besides, at this stage of development of the AYH/SRH manual, it is difficult to identify strategies/ interventions that are really evidence-based. In most countries, strategies and interventions which have been implemented have not really been evaluated in terms of their effectiveness and efficiency.

At the time of developing this it was difficult to identify really "good or best practices" in AYH for countries in the ECOWAS region, because there were inadequate evidence-based strategies and interventions.

However, it must be recognized that progress is being achieved in this area and that promising strategies and interventions are being identified. Indeed, some recent studies and international journals have reviewed some current strategies in the area of health services provision to adolescents and young people. Annex 3 lists some publications of current promising interventions and strategies.

6.1 Definition of the target groups

By targets, we mean the persons for which the interventions/strategies are designed. The following major targets may be identified:

- **Primary targets**

- adolescents and young people (girls and boys) of all social segments, different age groups, from rural, peri-rural and urban areas, undergraduates, educated, school dropouts, uneducated making life in the informal sector, learning a trade or not, etc.
- taking account of the country situation, other specific groups, such as key populations, differently-abled adolescents and young people.

- **Secondary targets**

- parents , guardians, teachers, family members of all categories without any distinction and discrimination.

6.2 Approach to identifying or choosing strategies/interventions

There are several approaches to identifying or choosing strategies. We have preferred the one which takes, as a basis, the determinants of AYH/SRH adopted in the strategic objectives. Once the targeted strategic objectives have been defined, at stage 4, the strategies/ interventions that are likely to achieve these objectives should be identified, taking into account the guiding principles.

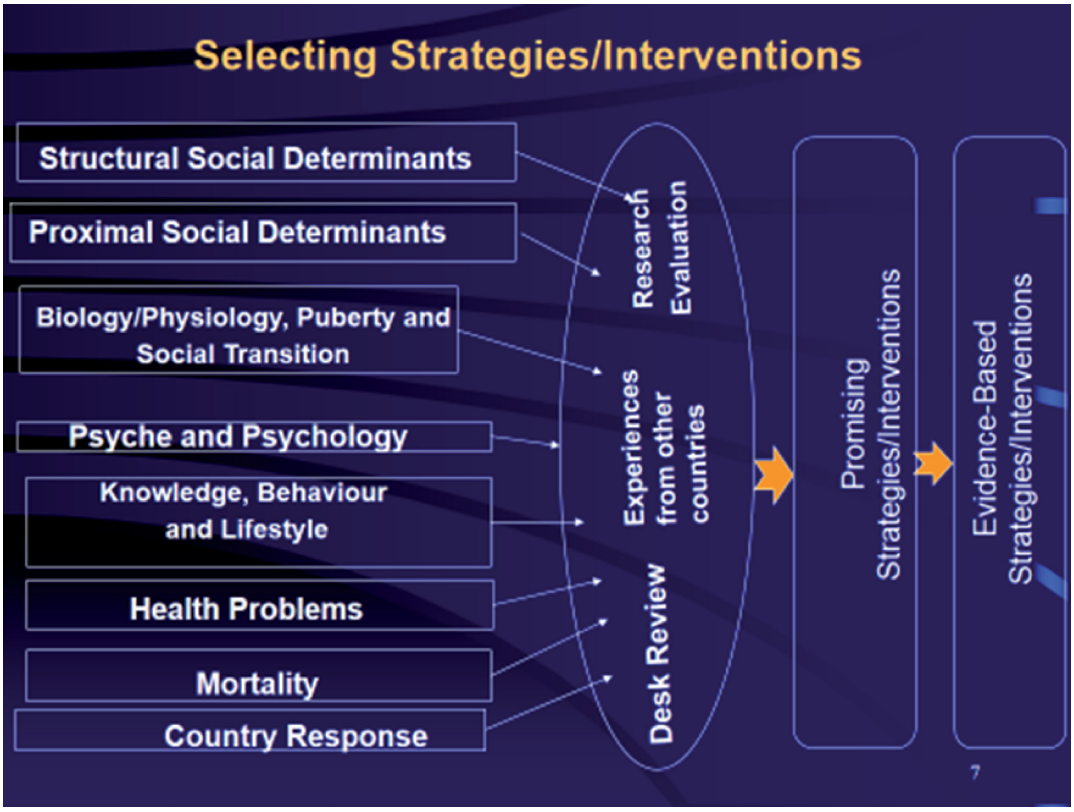
Improving the health and development of adolescents and young people should take into account all the determinants. It is the prerogative of the Ministry of health not to allow all stakeholders to cluster around the same determinant, in view of the interrelation between the determinants.

As shown in figure 4, this stage starts with the determinants in order to identify, through current evaluations and research, general literature review and even conclusive experiences of some countries, including evidence-based strategies/interventions that are likely to help achieve the set objectives.

But, in view of the current level of development in AYH/SRH, there are few strategies/ interventions based on substantiating data. As much as possible, we shall therefore do with promising strategies/interventions.

These strategies/interventions will mainly aim at 1) promoting the health and development of adolescents and young people, 2) preventing the health problems of adolescents and young people and, 3) managing adolescents and young people in the event of a health problem.

Figure 4: Choice of strategies/interventions



6.3 Promising strategies/interventions

For this section, we have put together strategies or interventions considered good or promising and from which countries can draw, during the preparation of the strategic document, while taking into account their context and peculiarities. These strategies/interventions have been organised in line with the health determinants of adolescents and youth. The list is not exhaustive and can be expanded as and when the manual is revised.

In view of the complexity and the multi-disciplinary character of AYH/SRH, it is important to note that integration and a combination of strategies can increase the chances of achieving success in implementation and subsequent desired results.

Publications relating to the strategies/interventions as well as their references are presented in annex 3

6.3.1 Some good or promising strategies/interventions targeting social determinants

- Education in general, especially secondary education
- Promoting and strengthening legal or policy measures with the participation of adolescents and youth.
- Promoting the economic “empowerment” of girls.
- Wide dissemination of information through communities, schools, traditional and new media, including social networks (Facebook, Twitter, Instagram, etc) frequently used by adolescents and young people.

These strategies/interventions, properly implemented, can also have an impact on other determinants such as proximal social determinants and those relating to the behaviour of adolescents and young people.

6.3.2 Some good or promising strategies/interventions targeting proximal social determinants

- Promoting the economic empowerment of girls
- Promoting parental/guardian commitment and communication between parents and children
- Peer education adequately implemented[7]
- At community level:
  - Mobilisation of adults and community leaders
  - Sensitisation of boys and men for the promotion of norms of equity and gender

6.3.3 Some promising strategies/interventions targeting knowledge, behaviour and lifestyle

- Creation of safe environments for girls, (establishing trust, promoting communication and dialogue)
- Wide dissemination of information through communities, schools and the media
- Adolescent and youth-friendly centres adequately established[8]
- Peer education implemented within programmes
- Promoting parental/guardian commitment and communication
- Promoting programmes targeting sexual partners
- Development of mentoring programmes through champions, role models and advocates
- At the community level:
  - Mobilisation of adults and community leaders.
  - Sensitisation of boys and men for the promotion of norms of equity and gender.
  - Combination of interventions
  - training of service providers.
  - improvement of appropriate service facilities.
  - and wide dissemination of information through communities, schools and traditional and new media, including social media.
  - Development of standards of quality service to adolescents and youth (Manual proposed by WHO).
  - Access to contraception.

7 *The substantiating data question the efficiency of peer education (PE) with regard to behaviour change among adolescents and youth. Even though PEs can contribute to increasing the knowledge of some youth, often it is the PEs themselves will benefit more from the activities, but the impact on other youth is limited.*

6.3.5 Some good or promising strategies/interventions targeting adolescents and youth health problems

- Combination:
  a. training of service providers
  b. improving appropriate service facilities
  c. wide dissemination of information through communities, schools and traditional and new media media
- Establishment of adolescent and youth-friendly health centers[9]
- Development of standards of quality services to adolescents and youth
- Access to contraception
- Focused antenatal care for pregnant adolescents
- Improved road safety standards (wearing of seat belts and helmets, etc)

6.3.6 Some good or promising strategies/interventions targeting puberty and social transition

This area has not yet received the necessary attention in ECOWAS countries. But one could think of preliminary strategies/interventions, as was previously done, such as initiatives at school to facilitate access of adolescent female pupils to appropriate conditions and infrastructure in the school during their menstrual periods and for general improvement of personal hygiene. For example, in Senegal, the School Medical Examination Division supported a project for the construction of toilets for the two sexes in order to guarantee privacy and the provision of sanitary towels and pads for girls.

Socio-anthropologists and psychologists can be brought in to assist.

6. 3.7 Some good or promising strategies/interventions targeting the psyche and psychology

This field has not yet received the necessary attention from countries. It is true that there are psychosocial support initiatives for adolescents especially those living with HIV as well as Guidance and Counselling in schools' in the sub-region[10]. However, psychologists and other specialists in social sciences can be brought in to explore the possible strategies/ interventions.

9 *The counselling and care centres for adolescence and youth can help improve access to information and knowledge. Substantiating data show that they are not necessarily efficient in increasing the use of health services by adolescence and youth.*

10 *http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0033690*
http://apps.who.int/adolescent/hiv-testing-treatment/page/Further_reading
http://www.aidsalliance.org/assets/000/000/338/219-Soutien-psychosocial_original.pdf?1405511271
http://www.sherpa-recherche.com/wp-content/uploads/2015/11/DIAPOS_2015_11_18.pdf

6.3.8 Some good or promising strategies/interventions targeting country response

There is limited published information on good and promising strategies/ interventions in member countries. However, suggestions gathered during country visits highlights the following points:

- Quality of coordination
- Efficacy of multidisciplinarity
- Involvement of all stakeholders, including adolescents and young people
- Existence of disaggregated data on adolescents and young people
- Alignment of interventions on the needs and priorities of adolescents and young people

Final outcome of stage 6	- Choice of strategies/interventions

STAGE 7: Definition of the institutional implementation framework

Taking into account the realities of each country, we shall limit ourselves to providing general guidelines for determining the institutional framework for implementing the provisions of the strategic document.

7.1 Critical conditions for implementation

The implementation of the national AYH/SRH strategic document will produce the expected results if some critical conditions are fulfilled, the most important of which are the following**:**

- **Political will**

Success in implementing the national AYH/SRH strategic document is tied to the actual commitment of policy makers in all the sectors involved at all levels. It will therefore be judicious to show political will leading to the creation of a favorable environment for the mobilisation of all key stakeholders and the necessary resources towards responding efficiently and effectively to the specific needs of adolescents and young people. Meanwhile, political will should translate into commitment and capacity of stakeholders to advocate at the national, sub-regional and regional levels for adolescent and young people's health.

- **Participation and buy-in of communities and families**

Communities and families, including young people as the cornerstone and targets of the various interventions, need adequate and reliable information in order to take ownership of the interventions adopted, and to foster the expected behaviour change. Communities and families should be at the center of the implementation of the strategies.

- **Capacity building**

This is an essential component, which constitutes a major concern for facilitating the implementation of this strategy. In this regard, it is important for the Ministry of health and

the other sectors involved to examine the various needs in terms of capacity building. This is because the issues of institutional support and development are of great significance for adolescent and young people's health and require substantial input in terms of transfer of skills, exchange of experiences and assistance to support the frameworks, service providers, communities and adolescents and young people themselves. Under these conditions the identification of needs in training will take into account the various issues and the weaknesses identified in the various sectors.

- **Multi-sectorality and leadership of the health sector**

The various sectors concerned (health, education, finance, planning, youth and social protection/welfare) have a lot to do to improve the health and development of adolescents and young people. However, the health sector has a crucial role to play through the various stakeholders, including government bodies, non-governmental organisations, civil society and the private sector. In consonance with the objectives and comparative advantages of WAHO, the ministries of health should contribute towards improving the health of adolescents and young people through the adoption of multi-disciplinary and multi-sectoral evidence-based approaches.

- **Resource mobilisation**

Resources always constitute an important aspect and a subject of concern in the implementation of policies and strategies. It is therefore logical that the mobilisation of resources, both internal and external, is done in a concerted manner for the implementation of this strategy. It is for reasons of greater efficiency, real ownership and better returns that resource mobilisation should be done holistically, thereby enabling all stakeholders and partners to share in common objectives. Under these conditions, all initiatives that contribute to resource mobilisation should fall within the framework for implementing the strategy.

7.2 AYH/SRH Coordinating and management bodies

An operational consultative and coordination system should be established to harmonise the implementation of interventions to promote adolescent and young people's health at all levels. Within this framework, the Ministry of health, in its capacity as an institution which ensures the coordination of AYH/SRH in most ECOWAS countries, should assume leadership and be involved at the highest level in order to mobilise all the other sectors. In view of the current and future health challenges and issues concerning adolescent and youth health, it is absolutely necessary to lay the foundation for a concerted global action, with technical and financial partners as well as implementing partners providing support to AYH/SRH. These partners should align with the major orientations of the strategic document.

Depending on the country's choice, AYH/SRH coordinating and management bodies shall be constituted at the national, intermediate and local levels. However, there should be no duplication of existing structures. Countries already having coordinating bodies can evaluate them and if necessary, strengthen them. The composition and mandate of each of these bodies should be clearly defined.

7.3 Roles and responsibilities of key stakeholders

Besides these organs, the roles and responsibilities of the various stakeholders should be defined.

Final outcomes of stage 7	- Coordinating bodies established and/or strengthened - Composition of the bodies and determination of their mandate - Roles and responsibilities of key stakeholders defined

STAGE 8: Selection of indicators and development of the Monitoring and Evaluation framework

Through monitoring and evaluation, the Ministry of health and all the other sectors involved shall provide sufficiently reliable and valid data to enable informed decision-making at all levels. To do this, one of the priorities of the Ministry of health shall be the implementation of a monitoring and evaluation system, which takes into account AYH/SRH activities from the community level up to the national level. As such, the monitoring and evaluation system should make available to all stakeholders at all levels and within the sectors involved, adequate management, reporting and decision making support tools. The incorporation of age and sex disaggregated data on adolescent and youth health into the tools of national health information system, including analysis and dessimination should be a priority for countries.The following aspects should receive a lot of attention in the monitoring and evaluation system: 1) improving the national health information system 2) formative supervision, coaching and mentoring, 3) monitoring-evaluation, 4) operational research and 5) indicators.

8.1 Improving the national health information system

This will involve strengthening the entire health information system from the status quo and using innovative mechanisms and tools that foster better operations and an improvement in the quality of data at all levels of the health pyramid. The coordinating unit of AYH/SRH at the Ministry of health should actively work with the unit responsible for managing the health information system in order to integrate disaggregated data on adolescents and young people.

8.2 Faciliting or formative supervision

Formative supervision shall be an essential element in monitoring and capacity building of the various stakeholders within the sectors involved. It shall be at the center of the national strategy on adolescent and young people's health. The integrated supervision techniques and methods shall be revitalised and strengthened at all levels of the health pyramid as well as in the other sectors involved. Meanwhile, the necessary resources for the implementation of promotional and supervisory activities should be made available to the various committees established. The monitoring of the activities under each committee

and under all the stakeholders involved shall be monthly, quarterly or half-yearly, depending on the resources of each country and their levels.

8.3 Monitoring and Evaluation

It is critical that the strategies and interventions rolled out be periodically monitored and evaluated in order to ensure that there is progress towards achieving strategic objectives and efficient use of resources for implementation of the strategies/interventions.

8.4 Operational or implementation research

Since AYH/SRH constitutes an evolving field, operational research on each of the determinants is necessary to generate knowledge that could make them more understandable in order to readjust the current strategies and interventions as well as identify new strategies / interventions.

8.5 Indicators

The monitoring and evaluation system established allows the measurement of four types of indicators:

- input indicators
- process indicators
- results indicators
- impact indicators

Input and process indicators particularly depend on the type of strategies/interventions as well as the activities adopted by the country.Table 7 presents a list of some indicators compiled from various sources for illustrative purposes.

Table7: Some examples of indicators

Categories of indicators	Indicators
Inputs	1. Percentage of the national budget allocated to the Ministry of health 2. Percentage of the budget of the Ministry of health allocated to maternal, new born, child, adolescent and youth health 3. **Percentage of the budget allocated to adolescent and youth health in relation to the national budget.** 4. Proportion of Health facilities that have service providers trained in the supply of integrated services appropriate to the needs adolescents and youth. 5. Number of facilities providing services and care appropriate to adolescents and youth align with intenational standards set by WHO
Process	1. Percentage of pregnant adolescents between 15 to 19 years who made at least 4 ANC visits 2. Number of young people who access services at adoescents and youth-friendly health centers at least once a month

Process	3. Percentage of countries that have included HPVas a routine immunization of adolescent girls 4. Percentage of adolescents and youth having knowledge on at least three components of adolescent and youth health (nutrition, physical activity, sexual and reproductive health, alcohol use, tobacco control and other substances that are harmful to health (psychoactives), road accidents). 5. Number of young people aged 15 to 19 with knowledge on modern contraceptive methods 6. Proportion of youth (15-24 years) who are using contraceptives methods 7. Proportion of youth (15 to 24years) who have adequate knowledge on HIV/AIDS 8. Proportion of men and women aged 15 to 49 who believe that if the husband has STI the wife is entitled to request the use of protection 9. Proportion of men and women aged 15 to 49 who have one reason or more to agree that the man is entitled to beat up his wife 10. The percentage of schools who conduct comprehensive sexuality education and lifeskills in the last academic year
Results	1. Percentage of pregnant adolescents (10-19 years) 2. Percentage of pregnant adolescents who have delivered with the assistance of skilled birth attendant 3. Percentage of pregnant adolescents who have undergone received HIV testing and counselling 4. Percentage of girls that have received 2nd dose of HPV in routine immunization in all countries. 5. Percentage of schools offering comprehensive sexuality education programs. (this may be called any other name by a country). 6. Percentage ofdistricts providing services to adolescents and youth in line with international standards. 7. Proportion of health facilities providing adolescent and youth-friendly integrated health services 8. Number of young people (10 to 24years) abusing drug and substances 9. Unmet needs of family planning by adolescent, both maried and unmarried (15-19) 10. Number of laws passed and implemented to create an enbling environment for adolescent and youth health 11. Literacy rates of youth aged between 15–24 years 12. Minimum age for access to contraceptives and to other SRH services without parental consent 13. Minimum age for access to voluntary screening for HIV (without parental consent) 14. Minimum legal age for marriage for young men and women 15. Situations in which voulntary interventon with pregnancy is legally authorised 16. Level of representation of adolescents and youth in of decision-making bodies, programming, implementation, monitoring and evaluation of programes concerning adolescents and youth. 17. Laws protecting the rights of sexual relations between people of the same sex 18. Laws specific to gender and sexual-based violence including rape, harrassment and domestic violence 19. Number of adolescent and youth organisations which have participated in decision-making, planning and implementation, monitoring and evaluation of AYH interventions.

Results	20. Percentage of adolescents and youth who report of having effectiveommunication on health and well-being with their parents during the past three months. 21. Percentage of men and women aged 15 to 24 who have sexual relationships by age 15 22. percentage of young women (15 to 24years) who have sexual relations during the last twelve months with a partner aged 10 years or more than themselves 23. Percentage of young girls aged 15 to 19 who are using any form of contraception
Impact	1. Mortality rate among adolescents 10 to 19 years 2. mortality rate of adolescents and young people10-24 years mortality rate of adolescents and young people 10-24 years from motors accidents mortalit rate of adolescents and young people of 10-24 from HIV/ AIDSmortality rate of adolescents and young people10-24 from suic mortality rate of adolescents and young people of 10-24 from homicide maternal mortality ratio among adolescents of 10 to 19 years 3. maternal mortality ratio among adolescentes and young people 10 to 24 years 4. Prevalence of depression among adolescents and young people of 10-24 years 5. Prevalence of sexual violence among the youth 6. Percentage of young people ages between 10 and 24 years living with HIV (women) 7. Percentage of young people aged between 10 and 24 years living with HIV(men) 8. Prevalence of other STIs among young aged between 10 and 24 years (disaggregated by sex) 9. Prevalence of anemia among girls 15-24 years 10. Prevalence of obesity among adolescents and young people of 10-24 years 11. Proportion of female adolescents underweight

Sources : [19, 20]

Final outcomes of Stage 8	- Indicators - Monitoring & Evaluation framework of the strategy implementation

STAGE 9: Drafting the Strategic document

This stage consists of putting together all the outcomes of the first 8 stages and organising them as a report. The structure of the document can vary depending on the country. However, these key elements should be considered:

- Introduction
- Background and justification
- Methodology
- Situation analysis

- Strategic framework
- Institutional implementation framework
- Monitoring and evaluation framework
- Conclusion

The drafting of the document is the responsibility of the technical team. It can be done through a workshop by the technical team and other resource persons.

Final outcome of Stage 9	- Draft Strategic Document

STAGE 10: Validating the Strategic Document

The principal task of this stage is the validation of the document by the steering committee.

Final outcome of Stage 10	- validated document

STAGE 11: Disseminating the strategic document

Dissemination should be the concern of all AYH/SRH stakeholders. Depending on the resources of the country, dissemination can be done at the national, intermediate and even peripheral levels.

Final outcome of Stage 11	- Strategic document disseminated

CONCLUSION

The health of adolescents and young people is crucial. It is therefore imperative for countries to have a national AYH/SRH strategic document based on proven strategies. This manual presents an approach in eleven (11) stagess for the development of national strategic documents. Like any other manual, it shall be improved upon as and when subjected to the test of countries' realities.

It has the advantage of systematising the approach for developing national strategic documents, while allowing each country to operationalise it, taking into account its own context.

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ANNEX

ANNEX 1: The Dakar Appeal to Improve Adolescent and Youth Health in the ECOWAS Region

Preamble

We, *participants at the Workshop to Validate the Orientation Guide for Establishing National Strategies for Adolescent- and Youth-Friendly Integrated Health Services in the ECOWAS region, which was held from 28 to 29 June 2016 in Dakar, Senegal****;***

1.1 ***Whereas*** *the Young people, aged between 10 and 24 account for over a third of the population of the West African region;*

1.2 ***Whereas*** *Adolescents and Young people in their diversity and status have specific health needs including sexual and reproductive health;*

1.3 ***Considering*** *the high exposure of Adolescents and Young people to mortality and morbidity due to sexually transmitted infections (STIs) including HIV and AIDS, early marriages, early and/or unwanted pregnancies, unsafe abortions, violence, accidents, and abuse of drugs and psychoactive substances*

1.4 ***Considering*** *that Adolescents and Young people's Health and well-being are key pillars to achieving sustainable development goals;*

1.5 ***Considering*** *that it is important to invest in Adolescents and Young people for the countries of the region to benefit from demographic dividend;*

We…..

Call on countries to use this validated guide to develop, implement, monitor and evaluate multi-sectoral policies and programs for enhanced Adolescent and Youth Health in the ECOWAS member countries.

Call on member countries to identify the appropriate institutional leadership to enable synergy of actions in the area of Adolescent and Youth Health (AYH).

Call on all stakeholders to support countries to develop, implement and evaluate Adolescent and Youth Health Policies and Strategies.

Urge the Governments of ECOWAS member countries and Technical and Financial Partners to support the financing of National Adolescent and Youth Health Policies and Strategies.

Done in Dakar on 29th June 2016

The List of participants is herewith attached

- Benin
- Burkina Faso
- Cap Vert
- Côte d'Ivoire
- The Gambia
- Ghana
- Guinea
- Guinea Bissau
- Liberia
- Mali
- Niger
- Nigeria
- Senegal
- Sierra Leone
- Togo
- Organisation Ouest Africaine de la Santé
- USAID/WA
- MSH/LMG/WA
- UNFPA
- OMS
- UNICEF
- UNESCO
- ONU Femmes
- EQUILIBRES & POPULATIONS
- E2A Project
- MARIE STOPE INTERNATIONA (MSI)
- SAVE THE CHILDREN /WCARO
- MEDECINS DU MONDE FRANCE / BF
- PARTENARIAT DE OUAGADOUGOU
- AfriYAN (African Youth and Adolescents Network)
- IPPF
- Gavi

ANNEX 2: Definitions of some key concepts

- **Adolescents, youth and young people**

  According to WHO, UNICEF and UNFPA, adolescents comprise persons aged between 10 and 19. These institutions also define "youth""as persons aged between 15 and 24 and "young peopleas persons aged between 10 and 24 [21].

  The definitions adopted within the framework of the development of this manual are those of WHO.

- **Adolescents and youth reproductive health (AYRH)**

  By reproductive health, we mean the general well-being, both physical and mental, of the human person with regard to the genital organ, its functions and functioning and not only the absence of disease or infirmities. This therefore presupposes that a person can safely live a satisfactory sexual life, be capable of procreating and free to do so as often or as less often as desired [22].

- **Adolescents and youth sexual health (AYSH)**

  The state of physical, emotional, mental and social well-being in relation to sexuality, which is not limited only to the absence of disease, dysfunctionalities or infirmities[22].

- **Sexuality**

  Sexuality is a central characteristic of the human being throughout life and it encompasses sex, identity and the role of men and women, sexual orientation, erotism, privacy and procreation. It is lived and expressed through thoughts, fantasies, desires, convictions, attitudes, values, behaviours, practices, roles and relations[22].

- **Adolescent and youth sexual and reproductive health (AYSRH)**

  In line with the preceding definitions, we can define AYSRH as a combination of sexual health and reproductive health.

- **Adolescent and youth health (AYH)**

  WHO adopted the term "adolescent health", as seen has been the case in its 2014 Report on adolescent health.

  According to WHO, the components of AYH are [7] :

  - Sexual and reproductive health
  - Sexually transmitted infections/HIV/AIDS
  - Nutrition
  - Physical activity
  - Tobacco control

- Drug and substance abuse
- Mental health
- Violence and injury prevention
- Integrated management of common conditions
- Immunization

ANNEX 3 : Some publications providing good or promising interventions

1. The paper published by Venkatraman et al reviewed four interventions commonly considered as best practices. They are: 1) adolescents and youth counseling and care centers, 2) peer educator approach, 3) public meetings and 4) overall sexual education. The authors noted that these interventions, even though they are theoretically efficient, did not however produce the expected results at the implementation stage. Implementation was a real challenge for these two interventions.They concluded that for sexual and reproductive health programmes to be efficient, there would be the need for solid coordination approaches and complementarity. (Venkatraman CM.; Lane C.,Wong Sylvia.What Does Not Work in Adolescent Sexual and Reproductive Health: A Review of Evidence on Interventions Commonly Accepted as Best Practices. Global Health Science and Practice. August 31, 2015 doi: 10.9745/GHSP-D-15-00126)
2. In their journal, Denno et al reported the results of an randomised study which showed that the approaches using a combination of training of service providers, improving service facilities that are appropriate for adolescents andyouth and a broad dissemination of informationthrough the communities, schools and the media (fostering acceptability by the communities and creating demand) produced better results. They, however, suggest the need for supplementary research. (Denno DMD: Hoopea A; Chandara-li V. Effective Strategies to Provide Adolescent Sexual and Reproductive Health Services and to Increase Demand and Community Support available at http://www.jahonline.org/article/S1054-139X%2814%2900424-8/pdf 1é Mars 2016)
3. Torres, in their journal, emphasised participation and promotion of leadership in the development of AYSRH policies and programmes.

(Torres LV ; Svanemyr . J. Ensuring Youth's Right to Participation and Promotion of Youth Leadership in the Development of Sexual and Reproductive Health Policies and Programs available at http://www.sciencedirect.com/science/article/pii/S1054139X14003310 -12 Mars 2016)

4. WHO developed service standards for adolescence, with a package of services [WHO]. « WHO Global Standards for Quality Health-Care Services for Adolescents »http://www.who.int/maternal_child_adolescent/documents/global-standards-adolescent-care. It is a Manual in four volumes: Volume 1 describes 8 standards for the supply of quality services to adolescents; volume 2 decribes how to implement the Manual; volume 3 presents the tools for measuring quality and coverage through surveys on compliance with standards; volume 4 discribes how to analyse the data.
5. OMS, 2013 "HIV and Adolescents : Guidance for HIV Testing and Counselling and Care for Adolescents living with HIV"http://apps.who.int/iris/bitstream/10665/94334/1/9789241506168_eng.pdf

This document provides a list of recommendations for interventions based on substantiating data for counseling, screening, treatment and care for adolescents living with HIV.

6. OMS, 2011 "WHO Guidelines on 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. This WHO document provides recommendations based on substantiating data for interventions to prevent early pregnancies and reproductive health problems among adolescents.
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8. UNFPA, 2015 "Girlhood not Motherhood" http://www.unfpa.org/publications/girlhood-not-motherhood. This document provides recommendations based on substantiating data for strategies to prevent pregnancies among adolescents.

ANNEX 4 : Some tools for situation analysis

ANNEX 4.1 : Country response questionnaire

SITUATION ANALYSIS OF ADOLESCENTS AND YOUTH HEALTH INCLUDING SEXUAL AND REPRODUCTIVE HEALTH

TOOL 1: COUNTRY RESPONSE QUESTIONNAIRE

SECTION 0 : COUNTRY

1. Benin /___/ 2. Cape Verde /___/ 3. Nigeria /___/ 4. Senegal /___/ 5. Sierra Leone /___/.

SECTION 00 : INFORMATION ON THE RESPONDENT

Surname and other names _____

Telephone _____

Position_____

Email_____

SECTION 1 : DEFINITION OF THE CONCEPTS OF ADOLESCENT AND YOUTH

QUESTIONS	RESPONSE
1. Which age group defines adolescents in your country?	
2. Which age group defines youth in your country ?	
3. Which age group defines adolescents and youth in your country?	

SECTION 2: STAKEHOLDERS: PARTNERSHIP AND COORDINATION FOR ADOLESCENT AND YOUTH HEALTH

QUESTIONS	YES	NO	OBSERVATIONS
Type of stakeholders /partners			
1. Does the country have strategic/operational partners who support adolescent and youth health interventions? 2. If yes, which and what are their areas of support and intervention?			
A. Ministries of health			If yes provide the list (Use Annex 1)
B. Ministries in charge of youth			If yes provide the list (Use Annex 1)
C. Other ministries in the country? : (Specify the names of the Ministries)			If yes provide the list (Use Annex 1)
D. United Nations Agencies			If yes provide the list (Use Annex 1)
E. International NGOs			If yes provide the list (Use Annex 1)
F. National NGOs			If yes provide the list (Use Annex 1)
G. Private sector			If yes provide the list (Use Annex 1)
H. Academic institutions			If yes provide the list (Use Annex 1)
I. Civil Society Organisations			If yes provide the list (Use Annex 1)
2. How is partnership/coordination organised for adolescent and youth health? And how does it function?			

SECTION 3: RIGHTS /ADVOCACY/NATIONAL LEADERSHIP/COORDINATION/RESOURCE MOBILISATION

QUESTIONS	YES	NO	OBSERVATIONS
1. Have the laws and legislation of the country determined a minimum age of marriage for boys and girls? If yes, what is the age for boys? If yes, what is the age for girls?			Produce document(s) as proof (electronic version if possible)*(Use Annex 2)* In case the law is being made, indicate what has been done
2. Does the health of adolescents and youth constitute a concern at the highest strategic level in the country (National authorities)			Produce document(s) as proof (electronic version if possible)*(Use Annex 2)*
3. Does the health of adolescents and youth constitute a priority at the highest strategic level in the country (National authorities)			Produce document(s) as proof (electronic version if possible)*(Use Annex 2)*
4. Does the health of adolescents and youth constitute a topic for advocacy at the highest strategic level in the country (National authorities)			Produce document(s) as proof (electronic version if possible)*(Use Annex 2)*
5. Is the right to health recognised in policies, strategies and health plans in the country, including those relating to adolescent and youth health?			Produce document(s) as proof (electronic version if possible)*(Use Annex 2)*
6. Has the country developed a national strategy paper or a roadmap for the reduction of maternal and neonatal mortality?			**IF YES,** ▪ Indicate start date: ▪ Indicate end date : Produce document(s) as proof (electronic version if possible) *(Use Annex 2)*

7. Has the country developed a national strategy paper for adolescence and youth?			**IF YES,** ▪ Indicate start date: ▪ Indicate end date: Produce document(s) as proof (electronic version if possible) *(Use Annex 2*
8. As the country developed standards for quality user-friendly health services in adolescent and youth health?			**IF YES,** ▪ Indicate date it was developed Produce document(s) as proof (electronic version if possible)*(Use Annex 2)*
9. Does the country have a national action plan for adolescence and youth?			**IF YES,** ▪ Indicate start date: ▪ Indicate end date: Produce document(s) as proof (electronic version if possible) *(Use Annex 2)*
10. Are public authorities engaged in the process of resource mobilisation (internal and external) in order to address adolescent and youth health?			Produce document(s) as proof (electronic version if possible) *(Use Annex*
11. Has the national action plan for adolescent and youth health been budgeted?			Produce document(s) as proof (electronic version if possible) *(Use Annex 2)*
12. Is there a unit or a focal point team for coordinating the adolescent and youth health programme? Is there an adolescent health unit/team/ focal point for coordinating adolescent health program at national level?			Produce document(s) as proof (electronic version if possible) *(Use Annex 2)*

13. Besides being beneficiaries of interventions, how are adolescents and youth involved in decision-making processes concerning their health problems?			Produce document(s) as proof (electronic version if possible)*(Use Annex 2)*
14. What provisions have been made in the laws and regulations to enable minors givetheir consent for medical procedures?			
15. What is the legal adult age in the country?			Produce document(s) as proof (electronic version if possible) *(Use Annex 2)*
16. For unmarried adolescents, what laws or regulations exist, authorising adolescent minors to give their consent for the following health services: A. Contraception services, with the exception of sterilisation? B. Immergency contraception? C. HIV test and counselling?			

SECTION 4: POLICIES, STRATEGIES AND DIRECTIVES FOR ADOLESCENTS AND YOUTH HEALTH

QUESTIONS	YES	NO	Observation
1. National situation analysis of adolescent and youth health			
A. Has the country undertaken a national situation analysis? If yes, does this report exist?			Produce document(s) as proof (electronic version if possible) *(Use Annex 2)* if yes, indicate the most recent date for the situation analysisUse the document's evaluation standard to assess the content of the situation analysis report
B. Does this situation analysis comprise the following disaggregated data?			Produce document(s) as proof (electronic version if possible) *(Use Annex 2)*
1. Age?			
2. Sex?			
3. Rural/Urban?			
4. Socio-economic factors?			
5. Socio-political factors?			
6. Does the situation analysis comprise information on the policy/strategic environment of the country?			
7. Does this situation analysis cover all levels (National level, intermediate level and peripheral leve)			
2. Adolescents and youth health in national policies/strategies			

A. Are adolescents and youth (10-24 years) mentioned as target groups for interventions/activities specified in the politicies/strategies for the following health problems?:			Produce document(s) as proof (electronic version if possible) *(Use Annex 2)*
1. Sexual and reproductive health, including the prevention of pregnancy among adolescents?			
2. Sexually transmitted infections/HIV			
3. Nutrition			
4. Diet and physical activities			
5. Tobacco			
6. Alcohol			
7. Harmful substances			
8. Mental health			
9. Prevention of t motor accidents 10. Injury prevention			
11. Violence			
12. Communication challenges between parent-adolescents and youth			
C. Does the country have specific strategies for adolescent and youth health? If yes, does it take into account the following major health problems?			Produce document(s) as proof (electronic version if possible) *(Use Annex 2)*

1. Sexual and reproductive health, including the prevention of the pregnancy among adolescents?			
2. Sexually transmitted infections/HIV			
3. Nutrition			
4. Diet and physical activities			
5. Tobacco			
6. Alcohol			
7. Harmful substances			
8. Mental health			
9. Prevention of motor accidents			
10. Violence and injury prevention			
11. Communication crisis between parent-adolescents andyouth			
D. Availability of national standards for service supply to adolescents and youth			
1. Does the country have the service supply standards specifically for adolescents andyouth (10-24 year)? If YES, do these standards indicate the following:			Produce document(s) as proof (electronic version if possible) *(Use Annex 2)* Indicate the year it was developed
A. A clear definition of adolescent and youth health risks			
B. A well defined package of health services?			

C. Specification of the group of adolescents to whom the services will be provided? If yes, does that package of interventions take into account the following adolescent and youth health problems?:			
1. Sexual and reproductive health, including the prevention of pregnancy among adolescents?			
2. Sexuality transmitted infections/HIV			
3. Nutrition			
4. Diet and physical activities			
5. Tobacco			
6. Alcohol			
7. Harmful substances			
8. Mental health			
9. prevention of motor accidents			
10. Violence and injury prevention			
11. Communication challenges between parents-adolescents andyouth			
D. Has clearly specified the training of service providers on adolescence and youth health			

SECTION 5: INTERVENTIONS AND SERVICE PROVISION TO ADOLESCENTS AND YOUTH

QUESTIONS	YES	NO	Observation
1. ADOLESCENTS AND YOUTH HEALTH INTERVENTIONS			
A. What major health problems do the adolescents andyouth face? (produce document(s) as proof (electronic version if possible) use Annex 2)			
B. What are the principal forms of unsafe health-related behaviour frequently observed among adolescents and youth? (produce document(s) as proof (electronic version if possible) use Annex 2)			
C. What does the country to do to promote adolescent and youth health? (produce document(s) as proof (electronic version if possible) use Annex 2)			
D. What does the country do to prevent adolescent and youth health problems? (produce document(s) as proof (electronic version if possible) use Annex 2)			
E. What does the country do in managing adolescent and youth health? (produce document(s) as proof (electronic version if possible) use Annex 2)			

F. Percentage of health districts providing appropriate services to adolescence and youth?			**Give the source of information:**
G. Does the country provide any service to adolescent and youth at the community level?			**If YES, give examples.** **If yes give some examples:**
2. AVAILABILITY AND UTILISATION OF SERVICES BY ADOLESCENTS AND YOUTH			
2. ARE THE FOLLOWING SERVICES AVAILABLE FOR ADOLESCENTS AND YOUTH:			**IF YES PROVIDE THE LIST OF INSTITUTIONS/FACILITIES INVOLVED (use Annex 3)**
1. Sexual and reproductive health including prevention of pregnancy among adolescent females?			
2. Sexually transmitted infections /HIV			
1. Nutrition			
2. Diet and physical activities			
3. Tobacco			
4. Alcohol			
5. Harmful substances			
6. Mental health			
7. Prevention of motor accidents			
8. Violence and injury prevention			

9. Communication challenges between :Parent-Adolescents and Youth			
2. B AVAILABILITY OF LISTENING AND COUNSELING FACILITIES / SERVICES BY ADOLESCENTS ET YOUTH			
1. Does the country have a *health services plan appropriate to adolescents and youth?*			
2. Are there Centres where adolescents and youth can be listened to in the country?			**IF YES PROVIDE THE LIST, WITH THE MANAGEMENT /FINANCIAL INSTITUTIONS (Use Annex 4)**
2.C EXISTENCE OF ASSOCIATIONS/ADOLESCENT AND YOUTH GROUPS			
Are there adolescent and youth associations in the country?			**IF YES PROVIDE A LIST (Use Annex 4)**
2.D EXISTENCE OF ASSOCIATIONS /PARENT ADOLESCENT AND YOUTH GROUPS			
ARE THERE PARENT, ADOLESCENT AND YOUTH ASSOCIATIONS /GROUPS IN THE COUNTRY?			**IF YES PROVIDE THE LIST (Use Annex 4)**
2.E EXISTENCE OF OTHER ASSOCIATIONS /GROUPS UNDERTAKING ACTIVITIES FOR ADOLESCENTS AND YOUTH			
Are there other associations /groups undertaking activities for adolescence and youth in the country?			**IF YES PROVIDE THE LIST (Use Annex 4)**
3. UTILISATION OF SERVICES BY ADOLESCENTS ANDYOUTH			

A. Percentage of female pregnant adolescents (15-19 years) in the country?			Provide the source of information
B. Percentage of adolescents aged between15 to 19 years who have received at least 4 ANC?			Provide the source of information
C. Percentage of pregnant adolescents aged between 15 to 19 years who have had assisted delivery provided by a qualified service provider			Provide the source of information
D. Percentage of adolescents aged between15 to 19 years who have receivedHIV screening and counseling			Provide the source of information
E. Percentage of pregnant adolescents aged between 15 to 19 yearsusing a modern contraceptive method			Provide the source of information
F. What sexually transmitted infections management services are provided to adolescent and youth clients?			Provide a list**(Use Annex 3)**
G. What health services are provided to adolescent and youth clients during pregnancy and delivery?			Provide a list**(Use Annex 3)**
H. Are abortion services provided to adolescent and youth clients? (where it is legal)			
I. Is information and counseling on emergency contraceptive use provided to adolescent and youth clients? If yes how ?			
J. Is care and support provided to adolescent and youth clients who HIV-positive?			
K. In case of sexual violence, what measures taken to manage adolescents and youth?			

SECTION 6: ADOLESCENTS AND YOUTH HEALTH IN FORMAL TRAINING PROGRAMMES

QUESTIONS	YES	NO	
1. Do the training programmes cover adolescent and youth health? If yes what strategies do countries use in the training activities?			
A. Basic training targeting students in training institutions			
B. Training during employment, targeting service providers			
C. Basic on-the-job training			
2. Is the teaching of health and development done as separate subjects?			
3. Health and development, are they integrated into other subjects (for example gynecology, pediatrics etc..) ?			
4. Health and development, are they seen as a crosscutting field?			
5. Estimate the percentage of health facilities that have at least one service provider trained in healthcare appropriate to adolescents			
6. Does the country have that training modules on adolescent and youth health?			

SECTION 7: SCHOOL HEALTH

QUESTIONS	YES	NO	
1. Does the country have school health policies/strategies for adolescents and youth?			Provide the year they were developed Provide document(s)as evidence (electronic version if possible) *(Use Annex 2)*
2. Does the country have a school health programme?			Provide the year they were developed Provide document(s) as evidence (electronic version if possible) *(Use Annex 2)*
3. How many public institutions are involved in the school health programme?			Provide the list (Use Annex 5)
4. How many TFPs are involved in the school health program?			Provide the list (Use Annex 5)
5. How many schools have a school health curriculum?			Provide the proportion
6. How many schools have implemented the school health program?			Provide the proportion

SECTION 8: FUNDING

QUESTIONS	YES	NO	
1. Financing the health of the mother, newborn ,Child and adolescent			
A. Percentage of the national budget allocated to the Ministry of health?			
B. Percentage of the budget of the Ministry of health allocated to maternal, newborn, child, adolescent and youth health?			
C. Has a budget being allocated to adolescent and youth health activities?			
D. Are adolescents aged between 15 and 19 exempted from paying for the following health services:			
a. ANC			
b. Deliveries?			
c. Consultations for curative healthcare?			
d. Insecticide-treated mosquito nets?			
e. HIV test and counselling?			
f. PMCT			

SECTION 9: MONITORING AND EVALUATION,

QUESTIONS	YES	NO	Observation
1. Which the adolescent and youth health indicators are adopted by the country?			Provide thelist (Use Annex 6)
2. Does the country conduct a half-yearly/annual monitoring of intervention coverage for adolescents and youth? If yes, does this monitoring include participation of adolescents and youth ?			Provide document(s) as evidence (electronic version if possible) *(Use Annex 2)*
3. Has the data on adolescents and youth been taken into account in the last DHS?			Provide document(s) as evidence (electronic version if possible) *(Use Annex 2)*

SECTION 10: HEALTH INFORMATION SYSTEM

QUESTIONS	YES	NO	Observation
1. Does the country publish statistical yearbooks? If yes, does the statistical yearbook cover health data on adolescents and youth?			Provide document(s) as evidence (electronic version if possible) *(Use Annex 2)*
2. Is the data on adolescent and youth health presented in the health information system disaggregated by age for the following age groups:			
a. 10-14 years?			
b. 15-19 years?			
c. 20-24 years?			
d. 15-24 years?			
3. Is the data on adolescent and youth in the national health information system presented by marital status?			Provide document(s) as evidence (electronic version if possible) *(Use Annex 2)*
4. Does the gender-disaggregated data on adolescent and youth in the national health information system mention adolescents and youth problems?			Provide document(s) as evidence (electronic version if possible) *(Use Annex 2)*
5. Is there data on adolescents and youth in the national health information system disaggregated under rural and urban			Provide document(s) as evidence (electronic version if possible) *(Use Annex 2)*
6. Is there data on adolescents and youth in the national health information system disaggregated by socio-economic status			Provide document(s) as evidence (electronic version if possible) *(Use Annex 2)*

SECTION 11: RESEARCH

QUESTIONS	YES	NO	Observation
1. Has the country undertaken national surveys on adolescents andyouth			**If yes, indicate the date of the most recent survey and the title of the survey:** **Provide the reports and the tools used** (Use Annex 2)
2. Does the country need research? If yes, what are the research needs?			

SECTION 12: IMPLEMENTATION OF THE FOLLOWING ACTIVITIES AND PROGRESS MADE IN THE COUNTRY

QUESTIONS	YES	NO	Observation
1. Prevention of child marriage and early pregnancy (among adolescent girls)			If YES, which institutions undertake these activities? (Use Annex 4)
2. Elimination of female genital mutilation/excision (FGM/E);			If YES, which institutions undertake these activities? (Use Annex 4)
3. Measures to encourage the use of a contraceptive method by sexually-active young people			If YES, which institutions undertake these activities? (Use Annex 4)
4. Measures to promote child education especially the girl-child and retaining them in school, particularly through to secondary school			If YES, which institutions undertake these activities? (Use Annex 4)
5. Elimination of all forms of violence against children			If YES, which institutions undertake these activities? (Use Annex 4)
6. Advocating for youth employment			If YES, which institutions undertake these activities? (Use Annex 4)
7. Sexual and reproductive health education, including the prevention and management of HIV/AIDS			If YES, which institutions undertake these activities? (Use Annex 4)

SECTION 13 : LESSONS LEARNED, CHALLENGES AND COUNTRY RESPONSE TO THE NEEDS OF ADOLESCENTS AND YOUTH

Lessons learned from the previous activities	Challenges	Country response

ANNEX 4.2 : Interview guide with adolescent and youth associations

SITUATION ANALYSIS OF ADOLESCENTS AND YOUTH HEALTH, INCLUDING SEXUAL AND REPRODUCTIVE HEALTH

TOOL 3: GROUP INTERVIEW GUIDE WITH ADOLESCENT AND YOUTH ASSOCIATION

SECTION 0: COUNTRY

1. Benin /___/ 2. Cape Verde/___/ 3. Nigeria /___/ 4. Senegal /___/ 5. Sierra Leone /___/.

SECTION 1 : CHARACTERISTICS OF THE ADOLESCENT AND YOUTH ASSOCIATION

QUESTIONS	RESPONSES
1. Name of the association	
2. Indicate the supporting Technical and Financial Partners	1. Public sector 2. United Nations Agencies 3. Bilateral institutions 4. International NGOs 5. National NGOs 6. Private sector 7. Academic Institutions 8. Civil Society Organisations
3. Areas of interventions (SRH, Nutrition, HIV etc)	
4. Levels of intervention implementation	1- National level 2- Intermediate level 3- Peripheral level
5. Contact address of the association	Telephone : Email :

SECTION 2 : DEFINITION OF THE CONCEPTS OF ADOLESCENT AND YOUTH

4. who is an adolescent?
- Which age bracket defines a male adolescent or female adolescent?
5. who is a youth?
- Which age bracket defines youth, in your opinion?

SECTION 3: HEALTH PROBLEMS AND UNSAFE HEALTH BEHAVIOUR OBSERVED AMONG ADOLESCENTS AND YOUTH

1. what are the major health problems facing Adolescents and Youth in your country?
2. What are the major forms of dangerous health behaviours frequently exhibited by adolescents andyouthin your country?
3. Whatare the factors that could explain this frequency of health and behaviour problems among adolescents andyouth in your country?

SECTION 4: HEALTH-SEEKING BEHAVIOUR

1. In general, what do the youth of your locality do in case of health problems?
2. What facilities do the adolescents and youth frequently resort to in case of health problems?
3. What do you think about these facilities, in terms of reception, patient management, privacy and user-friendliness?

SECTION 5: HEALTH SERVICES PROVIDED TO ADOLESCENTS AND YOUTH

1. What is the of health services provided to adolescents and youth in your locality?
2. What do you think of the costs of services provided?
3. Are there reasons why you will not go to the youth health facilities?
   If yes, what are these reasons?
4. How do you assess the setting of the t adolescent and youth health facilities?,

SECTION 6: ADOLESCENTS AND YOUTH HEALTH NEEDS

1. What do you think are the priority health needs of adolescents and youth? (information, communication, health services, comfort, safety)
2. Which of these needs do you think are currently met in your country ?
3. Which of these needs do you think are not currently being met ?

SECTION 7: PERCEPTIONS ABOUT HEALTH MEASURES TAKEN BY HEALTH AUTHORITIES IN FAVOUR OF ADOLESCENTS ANDYOUTH

1. What measures have been taken by the authorities of your country with regard to adolescentsandyouth health ?
2. What do you think of the efficiency of these measures?

3. What would you suggest to the the Minister of Health?

SECTION 8: SOURCES OF INFORMATION ON ADOLESCENTSANDYOUTH HEALTH

1. Do you think adolescents and youth are interested in information on their health?
2. If yes, what are the major sources of information on adolescent and youth health?
3. If no, why are they not interested in information on their health ?
4. What type of health information would be of interest to adolescents and youth?

SECTION 9: SOCIAL NETWORKS FOR ADOLESCENTS AND YOUTH HEALTH

1. What major social networks do adolescents and youth prefer?
2. Do you think information and communication technologies in general, social networks in particular,can play a role in the promotion of adolescent and youth health?

   How?
3. In your opinion,which of the networks would be the best channel for the dissemination of health information and the promotion of health?

SECTION 10: PARTICIPATION OF ADOLESCENTS AND YOUTH IN RESOLVING THEIR HEALTH PROBLEMS

1. Are adolescents and youth involved in the promotion of their health and wellbeing? If yes, how?

$

SECTION 11: SUGGESTIONS OF STRATEGIES TO IMPROVE ADOLESCENTS AND YOUTH HEALTH IN YOUR COUNTRY

ANNEX 4.3 : Interview guide with adolescent-youth centres

ADOLESCENTS AND YOUTH HEALTH SITUATION ANALYSIS, INCLUDING SEXUAL AND REPRODUCTIVE HEALTH

TOOL 5: INTERVIEW GUIDE WITH OFFICIALS OF ADOLESCENT AND YOUTH HEALTH FACILITIES

SECTION 0: COUNTRY

1. Benin /___/ 2. Cape Verde /__X_/ 3. Nigeria /___/ 4. Senegal /___/ 5. Sierra Leone /___/.

SECTION 00: CONTACT OF RESPONDENT

Surname _____

Other names_____

Position_____

Telephone _____

Email_____

SECTION 1: CHARACTERISTICS OF THE FACILITY

QUESTIONS	RESPONSES
1.1 Name of the facility	
1.2 Institutions of affiliation	1. Public 2. United Nations Agencies 3. Bilateral Institutions 4. International NGOs 5. National NGOs 6. Private sector 7. Academic Institutions 8. Civil Society Organisations
1.3 Areas of intervention	
1.4 Levels of implementation of interventions	1- National level 2- Regional level 3- District level
1.5 Contact address of the institution	Telephone : Email : Website :

SECTION 2 : INVOLVEMENT AND SUPPORT TO ADOLESCENTS AND YOUTH

1. What does your institution do with regard to Adolescent and Youth health in the country?
2. What strategies do you use to reach out to adolescents and youth?
3. What challenges do you face?

SECTION 3 : CHARACTERISTICS OF ADOLESCENTS AND YOUTH ATTENDING YOUR FACILITY

1. Age bracket of the youth ?
2. Which of the sexes (male or female) attend more frequently?
3. Level of education of majority of clients? (Educated, uneducated, school dropout) ?
4. Socio-economic level?

SECTION 4 : MAIN REASONS WHY R ADOLESCENTS AND YOUTH VISIT THE FACILTY

1. What are the main reasons for adolescents and youth visits to your facility?
2. Who refers them to your facility?

SECTION 5 : SERVICES PROVIDED BY YOUR ORGANISATION REGARDING THE HEALTH OF ADOLESCENTS AND YOUTH

Are the following categories of services povided by your facility? For adolescents andyouth ?	YES	NO	Observations
1. Sexual and reproductive health, including the prevention of pregnancy among adolescents ?			
2. Sexually Transmitted Infections/HIV			
3. Nutrition			
4. Physical activity			
12. 5. Tabacco Control			
13. 6. Prevention and management of Drug and subsatnce abuse			
14			
15. 7. Mental health			
16. 8. Prevention of motor accident			
17. 9. Prevention of violence and injuries			
18. 10. Managing challenges of Parent-Adolescents andYouth communication			

2. **What services /healthcare do you specifically offer adolescents andyouth ?**
   (counselling, Service provision, Screening, FP, Detoxification, ANC, Post-abortionservices etc..)
3. How is the service/healthcare provided by your organisation (warmth, confidentiality, integration of services) ?
4. Working days and opening hours?

SECTION 6: HEALTH PROBLEMS AND RISKY HEALTH BEHAVIOURS OBSERVED AMONGADOLESCENTS ANDYOUTH

1. What are the major health problems Adolescents and Youth frequently face in your country?
1 What are, the major forms of dangerous unhealthy behaviour frequently found among adolescents and youth in your country?
3. What are, are the factors that could explain the frequency of these health problems and unhealthy behaviour found among adolescents and youth in your country

SECTION 7: ATTENDANCE BY PARENTS OF ADOLESCENTS AND YOUTH

1. Do parents of adolescents andyouthattend your facility?
   If yes, for what reasons?

SECTION 8: ACTIVITY REPORT OF THE FACILITY FOR THE PAST YEAR (Request for report)

SECTION 9: RELATION WITH OTHER FACILITIES WITHIN THE COMMUNITY

Perception by the community with regard to the facilty

Collaboration of facility with other institutions within the community (Police, etc)

SECTION 10: YOUR SUGGESTIONS AND STRATEGIES TO IMPROVE HEALTH SERVICE PROVISION TO ADDRESS THE NEEDS OF ADOLESCENTS AND YOUTH

ANNEX 4.4 : Interview guide with parents of adolescents and youth

SITUATION ANALYSIS OF THE HEALTH OF ADOLESCENTS ANDYOUTH INCLUDING SEXUAL AND REPRODUCTIVE HEALTH

TOOL 4: INTERVIEW GUIDE WITH ASSOCIATIONSOF PARENTS OF ADOLESCENTS AND YOUTH

SECTION 0 : PAYS

1.Benin /___/ 2. Cape Verde /___/ 3. Nigeria /___/ 4. Senegal /___/ 5. Sierra Leone /___/.

SECTION 1 : CHARACTERISTICS OF THE ASSOCIATION

QUESTIONS	ANSWERS
1.1 Name of the association	
1.2 Institutions of affiliation	Public sector : Private sector
1.3 Contact person of the association	Telephone : Email :

SECTION 2 : DEFINITION OF THE CONCEPTS OF ADOLESCENT AND YOUTH

1. Who is an adolescent?
1. What age bracket defines adolescents?
2. What age bracket defines youth?

SECTION 3: HEALTH PROBLEMS AND RISKY HEALTH BEHAVIOURS OBSERVED AMONG ADOLESCENTS AND YOUTH

1. What major health problems do the Adolescents and Youth in your country frequently face?
2. What major forms of risky health behaviours are frequently found among adolescents and youth in your country?
3. what are the factors that could explain the frequency of these health problems and risky behaviours found among adolescents and youth in your country?

SECTION 4: HEALTH-SEEKING BEHAVIOUR

1. In general what do the adolescents and youth in your locality do in case of health problems?
2. Which facilities do the adolescents and youth fequently resorted to in case of health problems?

SECTION 5: COMMUNICATION: PARENTS AND ADOLESCENTS ANDYOUTH

1. Do you communicate with your children?

   If yes, on what issues?
2. What difficulties do your have in addressing these issues?
3. What do you need in terms of knowledge and experience to support your children in this transition phase from childhood to adulthood?

SECTION 6: CHALLENGES FACED AS PARENT IN SUPPORTING ADOLESCENTS YOUTH

What are the challenges faced as parents in supporting adolescents and youth?

SECTION 7: STRATEGIES TO IMPROVE THE HEALTH OF ADOLESCENTS AND YOUTH IN YOUR COUNTRY

ANNEX 5 : Need for Utilization of Evidence-based Data in Strategy Review or Development

1. What are Evidence-based Data?

Sources of evidence-based data are:

- Expert's knowledge;
- Research results/findings;
- Existing statistics;
- Policy assessment reports;
- Consultancy reports
- Assessment of policy options costs
- Results of economic modeling and statistics
- International guides from the United Nations agencies or other credible institutions

2. Relevance of Using Evidence-based Data

In the review or development phase of a health strategy for adolescents and young people, the use of evidence-based data can help you :

- Identify priority problems or potential target groups
- Clarify issues and better understand their occurrence, providing opportunities for potential solutions by target groups
- Identify effective interventions or strategies tailored to meet the needs of your target
- Acquaint yourselves with the expectations, prospects or positions of the various stakeholders with respect to the problems, their occurrence, management strategy
- Acquaint yourselves with the barriers that have impeded the implementation of strategies or interventions chosen in some places and that should be taken into account
- Identify barriers in the health system and in your settings that should be taken into account when developing or implementing the strategy
- Identify policy options and efficient as well as effective approaches to implementation of the strategy
- Gain relevant information for better budgeting
- Gain relevant information on your prospective donors, supporters or competitors

3. Selection of Sources in Order of Priority

1. Recommandations for Clinic Pratice (RCP)

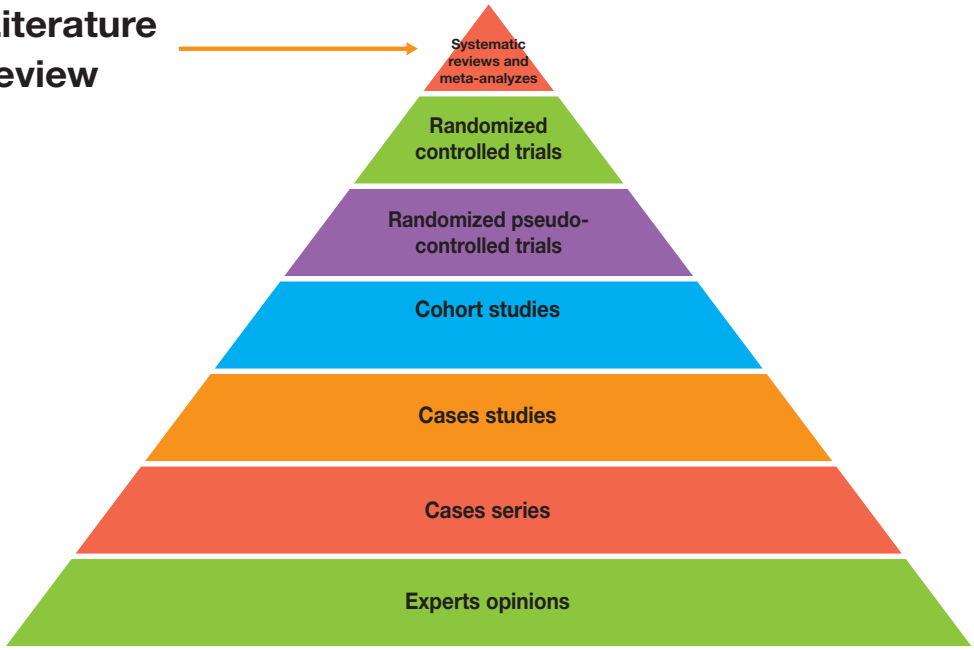
2. Cochrane Systatic Review
(therapeutics / prevention and dagnostic)

3. Medline / Pubmed Clinical Queries

4. CINAHL Clinical Queries
(especialy for qualitatives studies)

Evidences levels

Literature review



4. Facilitating the Use of Evidence-based Data

- Encourage good cooperation with in-house analysis divisions/units (researchers, statisticians and economists)
- Get decision-makers or practitioners to work together with in-house analysts
- Get analysts involved in all stages of policy or guidelines development
- Link development research strategies to all strategic/annual plans of departments or divisions
- View researchers as partners and not opponents
- Collaborate with academic and research institutions
- Train on the use of evidence-based data

5. Usage Patterns of Evidence-based Data

5.1. Instrumental Use

Evidence-based data isused while preparing policy documents, strategies, standards and health care policies. References to these data are quoted in the written paper/article.

5.2. Conceptual Use

Evidence-based data is used to improve understanding of the situation or provide new avenues in terms of strengths and weaknesses relating to the evolvement of certain actions

5.3. Persuasive Use

Here, Evidence-based data is an element of persuasion. Evidence-based data is used as a political tool and thus may justify specific evolvement of action or the lack of it.

5.4. Wider impact

Evidence-based data may exert an influence through an institution. It may be be synthesized and shared through networks of practitioners and researchers and bring about paradigm shifts in policy and community beliefs. Research enhances the accumulation of knowledge that could influence the thinking and acting of a group of people.

6. Need to Demonstrate That You Have Made Use of Evidence-based Data

It is important for various readers of the final paper to know that evidence-based data was used. Firstly, you may have to explain in your method that you have used evidence-based data and detailing how that evidence-based data was used. Secondly, you may quote the references used in the document. The source of your data may be at the bottom of the page or end of your document/article.

7. Sources of Evidence-based Data

www.scholar.google.com

http://www.cochranelibrary.com

http://www.ncbi.nlm.nih.gov

http://eppi.ioe.ac.uk/cms/

http://www.campbellcollaboration.org/lib/

http://www.scie.org.uk

http://www.who.int/topics/adolescent_health/en/

http://www.who.int/school_youth_health/en/

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West African Health Organization