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Strengthening the adolescent component of HIV/AIDS and reproductive health programmes

A training course for public health managers

World Health Organization

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Contents

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A. Introduction to the training course

This five-day training course on strengthening the adolescent component of HIV/AIDS and reproductive health programmes has been developed for public health managers. The course materials have been applied and further developed in courses throughout the world. They help public health managers to become familiar with the special health and development needs of young people, and to take those needs into consideration when planning interventions that aim to improve the reproductive health status of and reduce the prevalence of HIV infection among individuals from 10 to 24 years of age. A key assumption behind this course is that public health managers often have experience in designing and implementing HIV and reproductive health programmes but lack the understanding of what needs to be done differently to reach and serve young people. This course therefore presents the key concepts and approaches needed by a public health manager in order to plan HIV and reproductive health interventions and programmes that effectively address the needs of young people.

A.1 Overall course objective

After completing this five-day training course, public health managers will be able to plan HIV and reproductive health programmes that produce positive health and development outcomes among young people.

Supporting objectives

To meet the overall course objective, the participants will:

- understand how a young person is different from a child aged 5 or an adult aged 25;
- consider the particular needs of young people, and the importance of addressing those needs through action in various sectors;
- apply a systematic process for designing evidence-informed interventions and programmes that aim to achieve specific health and development outcomes among young people;
- list priority areas of action within the health sector for improving the health and development of young people;
- identify important types and sources of information needed to design, manage, monitor and evaluate interventions and programmes for young people;
- discuss approaches for improving the quality and coverage of health services provided to young people;
- explore how the health sector can stimulate and support action within other priority sectors;

- recognize the role of supportive evidence-informed policies in improving the health and development of young people;
- develop or revise a plan of action that aims to decrease the prevalence of HIV among young people and to improve their reproductive health status.

A.2 Course prerequisites

Participants of this course should be experienced managers of public health programmes, or managers of large nongovernmental organizations (NGOs) who are involved in the planning and management of HIV and reproductive health programmes.

A.3 Summary of course agenda

Day 1: Inauguration and course introduction, followed by: Introduction to adolescent health and development

- Understanding young people, with a focus on adolescents
- Global and regional overview
- Adolescent rights, diversity and vulnerability
- Why invest in adolescents?
- Day 1 wrap-up

Day 2: Programming for adolescent health and development using the MAPM framework

- Introduction to the Mapping Adolescent Programming and Measurement (MAPM) framework
- Using the MAPM framework to design or review programmes
- A closer look at determinants
- Planning for HIV and reproductive health programmes I
- Day 2 wrap-up

Day 3: Strategic approaches for addressing priority health and development issues

- Global goals and targets
- Strategic framework for programming
- The role of the health sector
- Strategic information
- Strategic information for programme monitoring and evaluation
- Day 3 wrap-up

Day 4: Scaling up health service provision and strengthening other sectors

- Introduction to scaling up health service provision to young people
- Making health services friendly for young people
- Strengthening other sectors
- Day 4 wrap-up

Day 5: Supportive policies and final planning

- Supportive evidence-informed policies
- Planning for HIV and reproductive health programmes II
- Evaluation of the course

A.4 Training materials

The training materials for this course are:

- Facilitator's guide (this document): contains the guidelines for facilitating each session over the five days and the talking points for the slide presentations.
- Presentations: PowerPoint presentations named and numbered by session.
- Handouts for participants: to be printed by facilitator and given to participants to use in sessions. The handouts are identified by their session number or a title.
- CD of background documents for participants: to be given to participants to use after the training. This resource is constantly being updated as tools and documents become available. An updated version can be requested from WHO's Department of Child and Adolescent Health and Development (cah@who.int).

B. Preparing for the course

B.1 Course logistics

- In order to allow more time during the course, the 90-minute inauguration and introduction to the course could be completed on the evening preceding the first day of the course. The additional time could be used for participants' presentation time or optional extra sessions.
- The agenda needs to be reviewed by the facilitator before the training and decisions made on optional sessions and participants' presentation time.
- The facilitator needs to consult with national programme staff and decide which national or regional documents will be reviewed by participants, and ensure that copies are available. Throughout the five days, participants will work in groups and review or develop a new document or project plan for their country (for example national HIV plan, national adolescent health plan, or chapter on adolescents in national reproductive health plan). They will determine if the plan identifies the health outcomes, behaviours and determinants that the proposed project aims to affect. If possible, it is useful to include an example of a strong plan and a weak plan in the materials. The way the working groups are divided will depend on the documents that are being reviewed. If participants can be linked to a document or a plan that is selected they can be divided into working groups in this way. More than one group can work on the same document.
- The facilitator needs to plan and invite speakers for session 1.2.3 *Problems and priorities at regional and country level*.

B.2 Preparation for facilitator

- The facilitator needs to be familiar with the training material and the material that is being presented. It is recommended that the facilitator reads the background documents, especially the MAPM manual, before the training.
- There is additional information on planning and preparing for participatory training in part I of the *Orientation programme on adolescent health for health-care providers*[1].

For each session the facilitator will need to:

- set up the computer/projector and load the presentations for that session, listed in the "materials" column on the agenda;
- have ready for each session the prepared flipcharts and handouts from the "materials" column of the daily agenda;
- show each slide and go through the talking points for that slide;
- complete the activities for each session;
- have available flipcharts with blank sheets, VIPP cards, marker pens and adhesive material or pins to hang up VIPP cards;
- review the session objectives with the participants at the end of each session.

[1] See http://www.who.int/child_adolescent_health/documents/9241591269/en/index.html

B.3 Participants' presentation time

Participants come to this training with a great deal of experience that is useful to share. Participants should be encouraged to tell their stories (work of their organization, situation in country, etc.). During the five days there are times in the agenda for participants' presentations. The facilitator will need to plan for these times (15 to 25 minutes each) and invite, ahead of the workshop, participants to make these presentations. Ideally, the facilitator should invite presenters with specific experiences that relate to the session topics of that day.

The handout guidelines for participants' presentation time should be sent to or given to participants beforehand to assist them in preparing their 5 to 10 minute presentation.

B.4 Importance of young people as participants

It is recommended that this training include young people as participants. Their involvement will provide health managers with an insight into planning HIV and reproductive health programmes for young people. The young participants should be chosen with care, so that they will be able to participate and express their views. Young people collaborating in health programmes as volunteers, peer counsellors etc. often make good participants.

The facilitator should meet with the young people before the course and prepare them for their role: to represent the perspectives, needs and experiences of young people. During group work, there should be a young person in each group whenever possible. The facilitator should be sensitive to the needs of the young people and assist them in feeling confident to speak up during the day.

B.5 Training methods

The training methods used are participatory, including VIPP, brainstorming and group work. These methods are described below.

Visualization in participatory planning (VIPP)

VIPP is a participatory process that is organized through participants writing their ideas and responses on cards of different sizes, colours and shapes. These are displayed and the linkages between ideas and areas of consensus and disagreement are identified. For VIPP to be successful there are some rules for card writing, as follows:

- write only one idea per card
- write a maximum of three lines on each card
- use key words
- write legibly
- follow the colour code established by the facilitator for different categories of ideas.

These rules are reviewed with the participants in the introduction to the training.

VIPP cards can be used in plenary or in small groups to get the participants to put down their responses to a question. It is important that the question asked be clear and unambiguous. The use of cards enables the responses to be organized in a logical way and to show areas of consensus and disagreement.

This methodology allows all participants the opportunity to express themselves, so that the quieter members in the group are able to make inputs. The facilitator needs to analyse the cards with the participants and make an assessment of what they represent. Then there can be a discussion on any areas of disagreement, to determine the underlying causes.

Card paper may not be readily available in some settings. In this case, long sheets of plain wrapping paper can be obtained and cut in advance into the different sizes and shapes needed for VIPP exercises. If different-coloured paper or cards are not available, different-coloured crayons or marker pens can be used.

Participants may be reluctant to apply some of the VIPP writing rules, such as limiting the number of words per card and writing in large letters. The facilitator can gently remind them of the importance of adhering to these rules because the aim is for their colleagues to be able to read the cards from a distance.

Brainstorming

Brainstorming helps quickly generate ideas that can be used as a basis for later discussion. This technique is often used at the beginning of a session. It involves posing a question and inviting participants to share their ideas. During the brainstorming stage, neither the facilitator nor the other participants should comment on any of the ideas that have been raised. The responses are usually written on a flipchart or on VIPP cards, which – at a later stage – can be organized to show the themes that emerged from the exercise. Once this has been done, the ideas can be examined and discussed.

It is important to decide in advance the reason for asking the participants to brainstorm and to plan how to deal with their responses. Make sure that the initial brainstorming question is clear and unambiguous. It is best to have the question written on a flipchart so the participants can also read the question when it is introduced. Do not let the session continue for too long; 10 to 15 minutes is best. Ensure that everyone has the opportunity to contribute.

Group work

Group work can help participants cooperate on a task, to focus on an issue or problem and to learn from each other's expertise. Groups can be small 'buzz' groups (two to three people talking together) or larger groups, either randomly grouped participants or participants who are colleagues, sharing responsibility for developing a common plan.

Participants will review the ground rules for participatory learning in the introduction to this training. These rules are important to ensure that the group work will be successful.

One of the handouts is titled *Instructions for group work*. The facilitator can print these instructions and distribute them to the participants (one copy for each group, a few copies for each group, or one copy for each participant). The facilitator can also write the instructions on a flipchart. However, for some work the instructions are quite long and participants may be

working in different rooms. It is very important that the groups understand the task they are being asked to complete.

Ice-breakers

Some of the sessions are long and participants may at times need a quick break to help them through these sessions. At the beginning of the training identify one to two participants for each day (i.e. a total of 5–10 participants) and ask them to prepare an ice-breaker (an activity of 2 to 3 minutes that will allow participants to move around, laugh and then refocus) to be used on a specific day. Write the participants' names down and check with them at the beginning of the day that they are prepared. Call on them to do their ice-breakers when they are needed. The facilitator should also have at least four ice-breakers prepared that can be used as back-up if needed.

C. Five-day agenda

Time	*Day 1:* Introduction to adolescent health and development	*Day 2:* Programming for adolescent health and development using the MAPM framework	*Day 3:* Strategic approaches for addressing priority health and development issues	*Day 4:* Scaling up health service provision and strengthening other sectors	*Day 5:* Supportive policies and final planning
08:30–10:00	Inauguration Course introduction	Administrative issues, flashback and agenda for day 2 **2.1 Introduction to the Mapping Adolescent Programming and Measurement (MAPM) framework**	Administrative issues, flashback and agenda for day 3 **3.1 Global goals and targets** **3.2 Strategic framework for programming**	Administrative issues, flashback and agenda for day 4 **4.1 Introduction to scaling up health service provision to young people**	Administrative issues, flashback and agenda for day 5 **5.1 Supportive evidence-informed policies**
10:00–10:30	*Break*				
10:30–13:00	**1.1 Understanding young people, with a focus on adolescents** **1.2 Global and regional overview**	**2.2 Using the MAPM framework to design or review programmes** **2.3 A closer look at determinants**	**3.2** (continued) **3.3 The role of the health sector** **3.4 Strategic information**	**4.1** (continued) **4.2 Making health services friendly for young people**	**5.1** (continued)  Participants' presentation time (optional) **5.2 Planning for HIV and reproductive health programmes II**
13:00–14:00	*Lunch*				
14:00–15:30	**1.3 Adolescent rights, diversity and vulnerability**	**2.3** (continued)  Participants' presentation time (optional)	**3.4** (continued)  Participants' presentation time (optional) **3.5 Strategic information for programme monitoring and evaluation**	**4.2** (continued)  Participants' presentation time (optional)	**5.3 Evaluation of the course** **5.4 Closing**
15:30–16:00	*Break*				
16:00–17:45	**1.3** (continued)  Participants' presentation time (optional) **1.4 Why invest in adolescents?** **1.5 Day 1 wrap-up**	**2.4 planning for HIV and reproductive health programmes I** **2.5 Day 2 wrap-up**	**3.5** (continued)  Participants' presentation time **3.6 Day 3 wrap-up**	**4.3 Strengthening other sectors** **4.4 Day 4 wrap-up**	

D. Aims for individual training sessions

The learning objectives for participants for each session of the training are given here.

Introduction to adolescent health and development (Day 1)

Session 1.1 Understanding young people, with a focus on adolescents

- Identify important positive and negative experiences of adolescence.
- Recognize three overlapping age groups – “young people”, “adolescents” and “youths”.
- Discuss the nature and sequence of changes that occur during adolescence.
- Discuss the public health importance of health and health-related behaviours among young people.
- (Optional session) Compare the experiences of adolescents today with the experiences of adolescents 10 to 20 years ago.

Session 1.2 Global and regional overview

- Discuss typical health problems and problem behaviours affecting adolescents globally and locally.
- Explain important issues to consider when developing a local list of priority health problems and risk behaviours for adolescents.

Session 1.3 Adolescent rights, diversity and vulnerability

- Explain the characteristics and principles of human rights.
- Describe how human rights can guide health planners to better address vulnerable populations.
- Explain how different subpopulations of young people are at different risk for health problems.
- Discuss how vulnerable groups may not have equal access to preventive and curative services.

Session 1.4 Why invest in adolescents?

- Present important reasons for investing in adolescent health and development.

Programming for adolescent health and development using the MAPM framework (Day 2)

Session 2.1 Introduction to the Mapping Adolescent Programming and Measurement (MAPM) framework

- Recognize the MAPM framework.
- Define the elements of the MAPM framework: health outcomes, behaviours, determinants and interventions.
- Describe how the MAPM framework links these elements together in a logical manner.
- Explain how the MAPM framework can be used to design or review programmes.

Session 2.2 Using the MAPM framework to design or review programmes

- Apply the MAPM framework to address a specific health or development outcome.
- Recognize similarities and differences – in terms of behaviours, determinants and interventions – between health outcomes (the prevention of HIV among young people, and the prevention of too early or unwanted pregnancy).
- Understand how the MAPM process helps define some specifics in behaviours, determinants and interventions that should be implemented or tracked.

Session 2.3 A closer look at determinants

- Define the terms “risk” and “protective factors”.
- Explain why it is important to classify determinants as risk or protective factors.
- Identify appropriate risk and protective factors for a specific health or development outcome.
- Prioritize risk and protective factors.

Session 2.4 Planning for HIV and reproductive health programmes I

- State the desired health and development outcomes of participants’ selected plans (national, regional, state, organizational, other).
- List key behaviours related to those health outcomes.
- Describe the determinants (risk and protective factors) of the priority behaviours (i.e. factors that influence adolescents to engage in each priority behaviour).
- Prioritize the determinants.

Strategic approaches for addressing priority health and development issues (Day 3)

Session 3.1 Global goals and targets

- Describe the international goals and targets that affect programming for adolescent health and development.
- Explain the relevance of global goals and targets to the participants' work.
- Explore how international goals could be translated into national goals.
- Identify other goals, at national or international level, that support adolescent health and development.

Session 3.2 Strategic framework for programming

- List key health and development needs of young people and the common settings through which those needs can be met.
- Explore how various settings could be better used to meet the needs of adolescents.
- Identify areas of strength and weakness in existing adolescent health and development programmes.

Session 3.3 The role of the health sector

- Discuss the ways that the health sector can contribute to meeting the health and development needs of adolescents.

Session 3.4 Strategic information

- Define the term "strategic information".
- Describe the types of information that are needed to develop and implement HIV and reproductive health programmes for young people.
- Identify information gaps in the participants' own countries, states and districts.
- Explore key challenges in collecting strategic information and how to overcome them.

Session 3.5 Strategic information for programme monitoring and evaluation

- Describe how the MAPM framework can be used to structure the monitoring and evaluation of programmes.
- List different tools that can be used to measure programming for young people.
- Identify relevant indicators for monitoring and evaluating HIV and reproductive health programmes for young people.

Scaling up health service provision and strengthening other sectors (Day 4)

Session 4.1 Introduction to scaling up health service provision to young people

- Define the terms “health services” and “health-related commodities”.
- Describe the roles that health workers and health services need to play in contributing to the needs of young people.
- Define the meaning of “youth-friendly” health services.
- Describe the obstacles that young people face in obtaining the health services they need.
- Discuss who young people go to when they face sexual and reproductive health problems.

Session 4.2 Making health services friendly for young people

- Name some initiatives that are under way in making health services friendly for young people in the participants’ country or region.
- Identify the characteristics that make these initiatives friendly for young people.
- Discuss the evidence of the effectiveness of initiatives to improve health service utilization by adolescents.
- Outline the elements of WHO’s approach to scaling up health service provision to adolescents.

Session 4.3 Strengthening other sectors

- List other sectors that are key for achieving desired health and development outcomes for young people.
- Identify ways that other sectors can be stimulated, engaged and supported.
- Assess to what extent the participants’ own countries, states or organizations are already working to strengthen other sectors.

Supportive policies and final planning (Day 5)

Session 5.1 Supportive evidence-informed policies

- Define the term “policy”.
- Explain the difference between a policy and a strategy.
- List the levels at which policies can be developed and applied.
- Discuss an approach for reviewing and presenting the evidence for policies.
- State the challenges and opportunities that policies present for accelerated action.
- Explore the roles that policies play in creating a safe and supportive environment.

Session 5.2 Planning for HIV and reproductive health programmes III

- List the evidence-informed policies needed within the health sector to support the desired health and development outcomes of participants' selected plans (national, regional, state, organizational, other).
- Make a personal plan of action, using the information gained through this training, to identify participants' personal role in advancing their plan for programmes that aim to decrease the prevalence of HIV among and improve the reproductive health status of young people.

DAY 1:
Introduction to adolescent health and development

Detailed agenda for day 1

Time	Minutes	Sessions and activities (minutes)	Materials
08:30	30	**Inauguration** Official opening of the course	
09:00	60	**Course introduction** Introduction of facilitators and participants (20) Course objectives and agenda (10) Introduction to participatory learning (5) Expectations and concerns (25)	**Presentation** Introduction 1 *Course objectives* **Flipcharts** Flipchart 1 *Introduce yourself!* Flipchart 2 *Expectations and concerns* **Handout** *Five-day agenda* **VIPP cards** VIPP rules written on five VIPP cards
10:00	30	Break	
10:30	90	**1.1 Understanding young people, with a focus on adolescents** 1.1.1 Introduction (5) 1.1.2 What do I remember about my adolescence? (35) 1.1.3 Changes that occur during adolescence (35) 1.1.4 What is special about adolescence? (15) 1.1.5 Adolescents today and 10–20 years ago (optional session, extra 20 minutes)	**Presentation** 1.1.2 *Definitions* **Flipcharts** Flipchart 3 *What do I remember?* Flipchart 4 *Positive and negative experience* Flipchart 5 *Changes during early adolescence* Flipchart 6 *Changes during middle adolescence* Flipchart 7 *Changes during late adolescence* Flipchart 8 *Characteristics of adolescence* Flipchart 9 (optional session) *Now and 10–20 years ago* **Handout** 1.1.3 *Changes that occur during adolescence* *Instructions for group work: session 1.1.3*
12:00	60	**1.2 Global and regional overview** 1.2.1 Introduction (5) 1.2.2 Health problems of adolescents at global level (15) 1.2.3 Problems and priorities at regional and country level (20) 1.2.4 Issues to consider when developing a list of local priorities (20)	**Presentation** 1.2.2 *Health problems of adolescents: global overview* **Flipcharts** Flipchart 10 *Local health problems and problem behaviours affecting adolescents* Flipchart 11 *Prioritizing health problems and problem behaviours affecting adolescents* **Handouts** *Guidelines for participants' presentations*
13:00	60	Lunch	

Time	Minutes	Sessions and activities (minutes)	Materials
14:00	90	**1.3 Adolescent rights, diversity and vulnerability** 1.3.1 Introduction (5) 1.3.2 Human rights: characteristics and principles (40) 1.3.3 Relevance of human rights to adolescent health (45)	**Presentations** 1.3.2 *Human rights: characteristics and principles* 1.3.3 *Duty bearers: who has a responsibility to act?* **Flipcharts** Flipchart 12 *Which groups are at risk?* Flipchart 13 *List of health issues* **Handouts** 1.3.3 *Adolescents and the Convention on the Rights of the Child (General Comment No. 4)* 1.3.3 *CRC case studies: the relevance of human rights to adolescent health and development* 1.3.3 *The CRC and health* *Instructions for group work: session 1.3.4* **VIPP cards** Three VIPP cards with feedback headings: "high", "intermediate" and "low"
15:30	30	Break	
16:00	35	**1.3 (continued)** 1.3.4 Diversity and vulnerability (35)	
16:35	55	 Participants' presentation time (optional) (15) **1.4 Why invest in adolescents?** 1.4.1 Introduction (5) 1.4.2 Debate (25) 1.4.3 Plenary review (10)	**Presentation** 1.4.3 *Main reasons for investing in adolescent health and development* **Flipchart** Flipchart 14 *Debate statement* **VIPP cards** Two VIPP cards with "arguments for" and "arguments against"
17:30	15	**1.5 Day 1 wrap-up**	**Flipchart** Flipchart 15 *Personal diary questions*

Inauguration and course introduction

Agenda for inauguration and course introduction	
00:30	I Inauguration: official opening of the course
00:20	II Introduction of facilitators and participants
00:10	III Course objectives and agenda
00:05	IV Introduction to participatory learning
00:25	V Expectations and concerns
01:30	

Note to facilitator

If the inauguration and the course introduction have taken place the day before, you will have already planned how to reschedule the day to use the 90 minutes for presentations from participants or optional sessions (see *Preparing for the course: course logistics*).

Distribute the name cards or tags when you greet the participants as they arrive. Ask the participants to write clearly the name they would like to be called during the programme – some people prefer their first name and others their surname. The name cards should be placed in front of each participant so that they can be seen by everyone; if using name tags, participants should be asked to wear them throughout the training.

Preparation

Presentation

Introduction 1 *Course objectives*

Flipcharts

- Flipchart 1 *Introduce yourself!*
- Flipchart 2 *Expectations and concerns*

Handout

Five-day agenda

VIPP cards

- VIPP rules written on five VIPP cards

- Two VIPP cards (two different colours, one with “expectations” written on it, the other with “concerns” written on it)
- Blank VIPP cards, enough of each of the two colours to give one of each to every participant
- Name cards or name tags

I. Inauguration

Objective

Formally open the training course.

Steps

a. Many stand-alone training courses are preceded by a formal opening ceremony in which representatives from key government departments and organizations are invited to speak. The formal opening is an opportunity to reflect on the importance accorded to adolescent health issues at national or regional level and to reiterate the continuing need for this.

b. When planning a formal opening, invite the speakers some time ahead and provide them with a copy of your provisional programme and the time available for speeches.

c. The speakers should provide factual information on adolescent health issues, resources available and ways of strengthening health service delivery.

d. You should have a list of available back-up speakers for the opening ceremony in the event that key representatives are not available to attend at that time.

e. It is important to minimize the risk that speeches in the opening ceremony run into the time of the course. One way to ensure this is to arrange for the opening to take place on the evening before the course begins. If this is not possible, stress the importance of keeping each speech to time or begin the workshop earlier than scheduled in the guidelines. It is possible to move the time of the opening ceremony and arrange for a short break immediately after the opening: this provides a target in terms of time, as well as an opportunity for guests and dignitaries to leave before the working sessions begin.

II. Introduction of facilitators and participants

Objective

Help facilitators and participants get to know each other and to feel comfortable working together.

Materials

Flipchart 1 *Introduce yourself!*

Steps

a. Welcome the participants to the course.

b. Introduce yourself and your co-facilitator(s). Be brief, as a model to the participants, using the points on Flipchart 1.

c. Explain that before starting the course a few minutes will be spent on general introductions, i.e. the participants and facilitators will each introduce themselves.

d. Show Flipchart 1 with the following points:

FLIPCHART 1 Introduce yourself!

Please tell the group about yourself:

- *your name*
- *the town or city where you work*
- *a few words about the organization for which you work*
- *what you do and whether you work with adolescents.*

e. Ask each person to introduce themselves, briefly covering the points on the flipchart. Say that this is only a quick introduction and we will learn more about each other during the five-day training.

f. After the introductions, stress that there is a wealth of experience among the participants present in the room. There will be much that every individual can share with and learn from others in the group.

III. Course objectives and agenda

Objectives

Summarize what the participants are expected to learn during the course.

Explain the five-day agenda.

Materials

Presentation: Introduction 1 *Course objectives* (with slide 5 *Ground rules for participatory learning*)

Handout: *Five-day agenda*

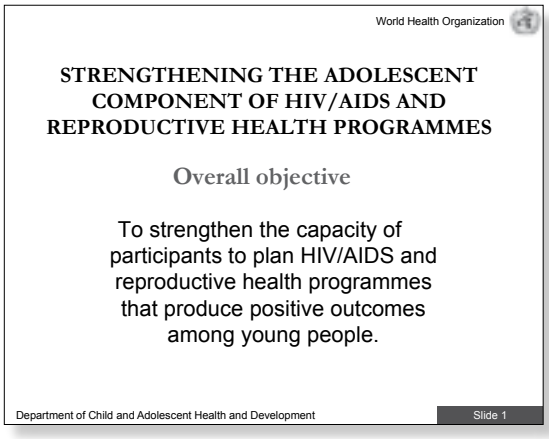
Steps

a. Distribute handout.

b. Show slides and go through talking points.

Talking points

Slide 1 Classification of diseases and health-related behaviours of young people in developing countries



This table divides diseases into five categories *[read the five headings in the first row of the table].*

Column 2 shows that some diseases, such as tuberculosis, and a few health-related behaviours, such as alcohol use, have a disproportionate affect on young people.

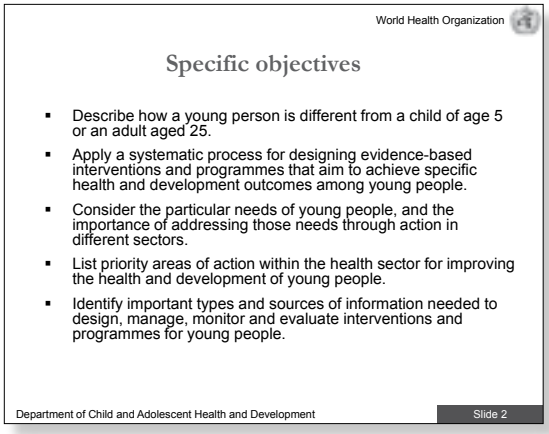
Column 3 demonstrates the importance of selected interventions in childhood, such as polio vaccination, in order to prevent illness in young people.

Column 4 highlights the need to promote healthy behaviours among young people, such as safe sexual practices, in order to prevent illness – such as HIV – later in life.

For many diseases listed in this table, young people will contribute a substantial number of cases, because they form a large proportion of the population in most developing countries.

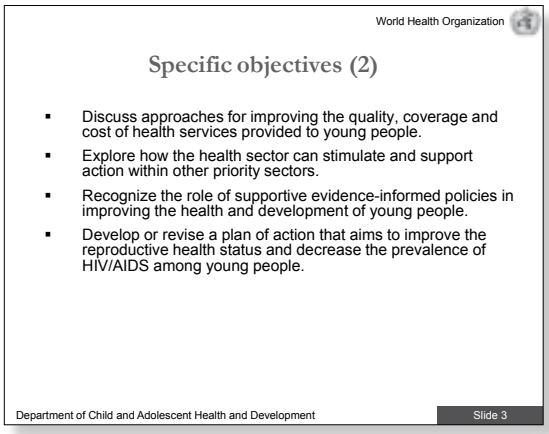
We will now look at some information, from a global perspective, on the mortality and morbidity caused by these health problems and problem behaviours.

Slide 2 Specific objectives



(Present the specific objectives.)

Slide 3 Specific objectives (2)

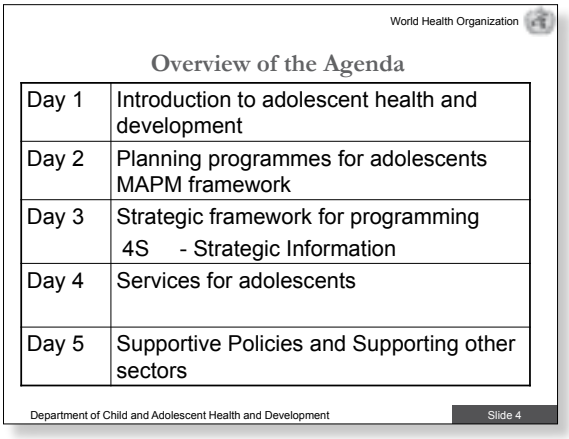


Slide 4 Overview of the agenda

This slide shows the general content of each training day.

Ask the participants to look at their five-day agenda.

Briefly take them through each day of the course, highlighting the main sessions for each day.



Note for facilitator: the last slide (Slide 5) in this presentation will be used in the next activity.

IV. Introduction to participatory learning

5 MIN

Objective

Introduce participants to the methodology used in this training.

Materials

Presentation: Introduction 1 *Course objectives* (with slide 5 *Ground rules for participatory learning*)

VIPP rules written on five VIPP cards

Steps

a. Ground rules for participatory learning

Slide 5 Ground rules for participatory learning

Read the slide with the participants.

Ask if there are any questions and respond.

b. VIPP rules and principles

Say:

VIPP stands for "visualization in participatory planning".

VIPP is a participatory process that is organized through participants writing their ideas and responses on cards of different sizes and colours (hold up example of VIPP card).

These are displayed and the linkages between ideas and areas of consensus and disagreement are identified.

For VIPP to be successful there are some rules for card writing.

Take the five prepared VIPP cards, read each one out and put it up in a column on the wall where it can be seen by all participants.

- One idea per card
- Maximum of three lines
- Use key words, write legibly
- Follow the colour code
- Do not write lots of words or ideas on one card so no one can read it.

c. Introduce the *Matters arising* board

Tell participants that this is where questions or comments that come up can be "parked", so that if they cannot be responded to immediately, they can be responded to later.

d. Feedback and evaluation

Tell participants that at the end of each day we will have a daily wrap-up activity, when participants will be asked to write in their personal diary (this can be their notebook or sheets of paper). Here they will write:

- what they found particularly useful today
- what they plan to do differently as a result of what they learnt today.

In preparation they should make notes and comments on the course during the day to use during the wrap-up activity. They can use their handout (*Five-day agenda*) to remind them of particular sessions.

At the end of the training, on day 5, they will use their personal diary to assist them in making a personal plan for strengthening the adolescent component of HIV/AIDS and reproductive health programmes.

Ask if there are any questions or comments and respond.

V. Expectations and concerns

Objectives

Review the participants expectations of the course.

Discuss any concerns they may have.

Materials

Flipchart 2 *Expectations and concerns*

Two VIPP cards (two different colours, one with “expectations” written on it, the other with “concerns” written on it)

Blank VIPP cards, enough of each of the two colours to give one of each to every participant

Steps

a. Show Flipchart 2.

FLIPCHART 2 Expectations and concerns

What is your most important expectation about this course?

What is your most important concern about this course?

b. Show the two coloured VIPP cards with the following headings:

Expectations *Concerns*

Stick them on the flipchart or the wall with enough space to put the participants’ cards underneath.

c. Explain that during this exercise we will identify participants’ expectations and concerns related to the course.

d. Tell participants that they have a few minutes to write their most important expectation and their most important concern about this course on the appropriate VIPP card. Remind them that their response will be anonymous.

e. Remind them of the five VIPP card rules to be followed.

f. When they have written their two cards they should put them face down on their desk.

g. The facilitator will gather them up without looking at them.

Plenary feedback occurs when all the cards are gathered. The facilitator then reads the cards aloud and sticks them up, grouping cards with similar ideas.

Point out common themes and opposites. Respond to questions or misconceptions.

Ask for additional comments or questions. Tell participants we will come back to these cards at the end of the training.

Thank everyone for their participation.

Session 1.1 Understanding young people, with a focus on adolescents

Session objectives

This session explores the meaning of adolescence and its implications for public health.

By the end of this session participants will be able to:

- Identify important positive and negative experiences of adolescence;
- Recognize three overlapping age groups: "young people", "adolescents" and "youths";
- Discuss the nature and sequence of changes that occur during adolescence;
- Discuss the public health importance of health and health-related behaviours among young people;
- (Optional session) Compare the experiences of adolescents today with the experiences of adolescents 10 to 20 years ago.

Preparation

Presentation

1.1.2 *Definitions*

Flipcharts

- Flipchart 3 *What do I remember?*
- Flipchart 4 *Positive and negative experience*
- Flipchart 5 *Changes during early adolescence*
- Flipchart 6 *Changes during middle adolescence*
- Flipchart 7 *Changes during late adolescence*
- Flipchart 8 *Characteristics of adolescence*
- Flipchart 9 (optional session) *Now and 10–20 years ago*

Handout

1.1.3 *Changes that occur during adolescence*

1.1.1 Introduction

Materials

Handout: *Five-day agenda*

Steps

a. Go through the objectives of session 1.1 on the handout.

b. Explain the activities planned for the session and the time allocated for each activity.

Agenda for understanding young people, with a focus on adolescents	
00:05	1.1.1 Introduction
00:35	1.1.2 What do I remember about my adolescence?
00:35	1.1.3 Changes that occur during adolescence
00:15	1.1.4 What is special about adolescence?
00:20	1.1.5 Adolescents today and 10–20 years ago (optional session, extra 20 minutes)
01:30	

c. Ask if the participants have any questions.

1.1.2 What do I remember about my adolescence?

Objectives

Identify important positive and negative experiences of adolescence.

Recognize three overlapping age groups: “young people”, “adolescents” and “youths”.

Note to facilitator: This exercise may unleash strong feelings, such as sadness or anger. Be prepared to respond if any participants wish to talk about their thoughts and feelings.

Materials

- Flipchart 3 *What do I remember?*
- Flipchart 4 *Positive and negative experience*
- One VIPP card for each participant

Steps

a. Individual exercise (5 minutes)

- Show Flipchart 3 and read the instructions:

FLIPCHART 3 What do I remember?

Write down one key experience of your own adolescence that remains alive in your memory.

- Explain that each participant should write down on a VIPP card (in not more than 10 words) one powerful experience that stands out from their adolescence.
- Tell them that the experience can be positive (happy) or negative (unhappy).
- Give examples, such as:
  The death of my father (great loss, but also a sudden realization that I was no longer a child).
  My first kiss (my first emotional relationship with a boy/girl).
- Check that everyone has understood what to do.
- Reassure the participants that the responses will be anonymous. Go through the VIPP rules.
- Tell the participants that when they are finished writing they should put their cards face down on their desk. The facilitator will gather them without looking at them.
- Give one VIPP card and a marker pen to each participant.
- Tell the participants that they have 1 minute to write on their cards.

b. Plenary feedback (25 minutes)

- Show Flipchart 4 *Positive and negative experiences* with the following headings:

FLIPCHART 4 Positive and negative experiences

Positive/happy experience	*Negative/unhappy experience*

- Ask two participants to come forward to help facilitate the activity.
- Ask one of them to pick up a card and read it out to the group.
- Ask the group to decide the category (positive or negative) under which the experience belongs.
- Attach the card to the flipchart under the correct heading.
- Ask the other participant to pick up a card. Ask the group to decide to which category it belongs. Work as quickly as possible, alternating back and forth between the two participants.
- Be prepared to deal with a lack of agreement in assigning the cards to a category (positive or negative).
- *Mark the turning points.* Some experiences, such as failure in an important examination, spur us to work harder or to change our behaviour in some way. These may be remembered as important turning points. Ask participants if they would like to place a mark, such as a star, to highlight these cards.
- If needed, add a new category between the two headings, such as “happy/unhappy”. Ask the participants to suggest a heading.
- Continue until all the cards are attached to the flipchart.

c. Mini-lecture (5 minutes)

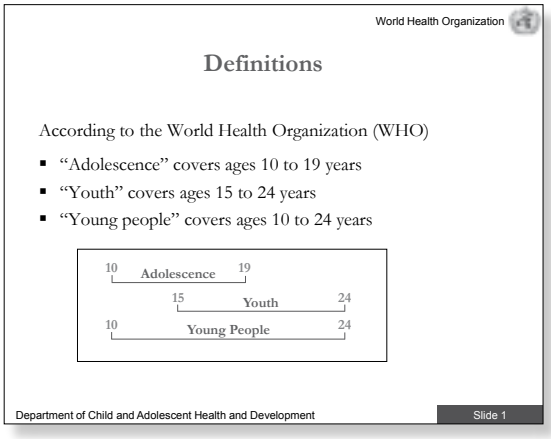
Presentation: 1.1.2 *Definitions*

- Introduce the terms and the age bands shown in Presentation 1.1.2.
- Go through the talking points and questions.

Talking points

Slide 1 Definitions

- The World Health Organization (WHO) defines "adolescents" as individuals from 10 to 19 years of age, and "youths" as those 15 to 24 years of age. These two overlapping age groups are combined in a group called "young people", which covers the age range from 10 to 24 years.
- WHO acknowledges that adolescence has both biological (physical and psychological) and sociocultural dimensions.
- WHO also acknowledges that adolescence is a phase in an individual's life rather than a fixed age band, and that this phase is perceived differently in different societies.



Questions

- How do you feel about these age bands?
- In your country, would someone aged 10 be considered an "adolescent"? Why?
- Would someone aged 24 be considered a "young person"? Why?
- Why do you think these age groups overlap?

(Note the importance of taking into account individual development, not years)

Tell participants that adolescent development can be divided into three stages:

- early adolescence: generally ages 10–15 years
- middle adolescence: generally ages 14–17 years
- late adolescence: generally ages 15–19 years.

During this training, we may use the terms young people and adolescents interchangeably at times, as we consider the needs of young people aged 10–24. There are some issues where it is more important to be specific and focus on the adolescent age group (aged 10–19 years), such as when we are discussing rights, the law and issues around consent.

1.1.3 Changes that occur during adolescence

35 MIN

Materials

- Flipchart 5 *Changes during early adolescence*
- Flipchart 6 *Changes during middle adolescence*
- Flipchart 7 *Changes during late adolescence*
- Handout: 1.1.3 *Changes that occur during adolescence*

Steps

a. Group exercise (5 minutes introduction and 15 minutes group work)

- Divide participants into three groups by counting off individuals in turn: 1, 2, 3. The "ones" will form a group, the "twos" a second group, and the "threes" a third group. Each group should have a mix of participants with different backgrounds.
- Have each group move together into one corner of the room.
- Give each of the three groups one of the following flipcharts and a pen.

FLIPCHART 5 Changes during early adolescence – Group 1

Events/changes that occur	Early adolescence (10–15 years)
Physical	
Psychological *– Cognitive* *– Emotional*	
Social	

FLIPCHART 6 Changes during middle adolescence – Group 2

Events/changes that occur	Middle adolescence (14–17 years)
Physical	
Psychological *Cognitive* *Emotional*	
Social	

FLIPCHART 7 Changes during late adolescence – Group 3

Events/changes that occur	Late adolescence (15–19 years)
Physical	
Psychological *Cognitive* *Emotional*	
Social	

- Explain that during this exercise each group will identify events or changes in adolescence that occur in each of these categories: *physical, psychological* and *social.* Each group will work on a different stage of adolescence (e.g. group 1 will explore early adolescence and consider the physical, psychological and social changes and events of that age band). Point out that the ages in each age band overlap because the changes are individual and do not happen at a certain age.
- Each group will identify up to three changes or events for each of the three categories: *physical* changes and events, *psychological* changes and events and *social* changes and events. There will be overlapping changes and events in the three categories.
- Encourage the participants to think about whether the events or changes they identify relate to male adolescents, female adolescents or both (gender perspective).
- Tell the participants that they have 15 minutes to complete their part of the table. One participant from each group will be asked to present their flipchart.

Instructions for group work: session 1.1.3

Divide participants into three groups.

Each group needs to appoint a rapporteur, who will fill in the flipchart and report back to the group in plenary.

- *Each group will identify events or changes in adolescence that occur in each of these categories:* physical, psychological *and* social. *Each group will work on a different stage of adolescence (early, middle and late adolescence).*
- *Each group will identify up to three changes or events for each of the three categories:* physical *changes and events,* psychological *changes and events and* social *changes and events. Some of these changes and events will overlap in the three categories.*
- *Think about whether the events or changes identified relate to male adolescents, female adolescents or both.*
- *Groups have 15 minutes to complete their part of the table.*

b. Plenary feedback (15 minutes)

- After 10 minutes of group work, give the groups a 5-minute warning. Then ask the participants to return to their seats in plenary.
- Ask the representative from each group to come forward to present their flipchart. Let the group presenting add any comments but ask the others to wait until all three groups have presented before beginning a general discussion.
  - It is likely that one or more groups will point out that the events and changes they identified do not "fit" into only one box, but extend across other boxes in the table, both horizontally and vertically. Acknowledge that this is an important point, and ask participants to look for this in other events and changes that were identified.
  - Some participants may mention that the events and changes being discussed are due to underlying factors, such as inherited traits and hormonal changes. Acknowledge that this is an important observation. Stress that the focus of this session is on the events and changes themselves, and not on the factors that cause them.

- After all three groups have presented, ask for additional comments or questions. Encourage a brief general discussion.
- Finally, thank the participants for their participation. Give them Handout 1.1.3 *Changes that occur during adolescence* or refer them to the list on the course CD that summarizes the main changes and events during adolescence.

1.1.4 What is special about adolescence?

Materials

Flipchart 8 *Characteristics of adolescence*

Steps

a. Brainstorming (5 minutes)

- Explain that we will briefly brainstorm on the characteristics that make adolescence such a special stage in an individual's life. This will form the basis for exploring health issues from an adolescent's point of view.
- Show Flipchart 8 with the following words at the top (brainstorming heading):

FLIPCHART 8 Characteristics of adolescence

The second decade: "No longer children, not yet adults"

What are the characteristics that make adolescence such a special stage in an individual's life?

Characteristics of adolescence

- Suggest one example to get the process started. Or ask one of the adolescents in the room if they could give an example, and then ask others. Typical examples are:
  - "wanting to be different from my parents"
  - "always hungry"
  - "unruly" or "disobedient"
  - "energetic" or "inquisitive".
- Explain that anyone is welcome to raise their hand and make a suggestion, and that you will consider all suggestions.
- Invite one volunteer to writing down the suggestions on the left side of the flipchart (leaving the right side for the next question).
- Once the flow of suggestions slows down, move onto the next step.

b. Brainstorming and discussion (10 minutes)

- Write "Implications for public health" on the right side of the flipchart in a different colour pen.
- Ask participants to now think about the public health implications for these special characteristics of adolescence. These may be positive or negative implications.
- Ask the volunteer to write up the participant suggestions in the different colour in a column to the right of the appropriate characteristic on the flipchart.
- The flipchart will now look similar to this:

FLIPCHART 8 Characteristics of adolescence

The second decade: "No longer children, not yet adults"

What are the characteristics that make adolescence such a special stage in an individual's life?

Characteristics of adolescence	Implications for public health
Peers become more important	*Peer education can be an important way to introduce key health messages*
Awkward in interacting with adults	*Health-care providers need training on how to best deal with adolescents*

- Say: When health workers are aware of the characteristics of adolescents they can work with these characteristics to provide appropriate health services.
- Thank the participants and ask if there are any questions.

1.1.5 Adolescents today and 10–20 years ago

(Optional extra session comparing the experiences of adolescents today with adolescents 10–20 years ago).

Materials

Flipchart 9 *Now and 10–20 years ago*

Steps

a. Show a flipchart with the following question:

FLIPCHART 9 Now and 10–20 years ago

How are the experiences of adolescents today different from those 10 to 20 years ago?

Please give reasons to support your answer.

b. Example answers might include:

- "Onset of puberty comes earlier for today's adolescent girls."
- "Adolescents have other sources of information about sex and sexuality today."

c. As the participants respond to the question, note on the flipchart the points of similarity to and difference from adolescents of 10 to 20 years ago.

d. Encourage interaction between the participants.

e. Emphasize that the range of different experiences during adolescence can be attributed to differences in sex, age, family environment, socioeconomic conditions, culture, place of residence, etc.

f. Thank the participants and tell them that their participation enriched the learning process for this activity.

Session 1.2 Global and regional overview

Note to facilitator

As stated in the introduction, before the training course begins the facilitator needs to ensure the presentations are prepared for this session. The facilitator can prepare a 10-minute presentation on the regional or country overview of the adolescent health and development situation, or ask one of the participants or a guest speaker (e.g. representative from the ministry of health) to prepare and give this short presentation.

Before the training, another participant will have been asked to prepare a 10-minute presentation on a case study or example that introduces a priority health problem among adolescents in their country, state or district.

To help participants prepare their presentations before the course, they should receive a copy of the handout *Guidelines for participants' presentation*.

Session objectives

Discuss typical health problems and problem behaviours affecting adolescents globally and locally.

Explain important issues to consider when developing a local list of priority health problems and risk behaviours for adolescents.

Preparation

Presentation

1.2.2 *Health problems of adolescents: global overview*

Flipcharts

- Flipchart 10 *Local health problems and problem behaviours affecting adolescents*
- Flipchart 11 *Prioritizing health problems and problem behaviours affecting adolescents*

Other

Load presentations or prepare other materials as requested by guest presenters.

1.2.1 Introduction

5 MIN

Agenda for global and regional overview	
00:05	1.2.1 Introduction
00:15	1.2.2 Health problems of adolescents at global level
00:20	1.2.3 Problems and priorities at regional and country level
00:20	1.2.4 Issues to consider when developing a list of local priorities
01:00	

60 MIN

Materials

Handout: *Five-day agenda*

Steps

a. Go through the objectives for session 1.2 using the handout.

b. Explain the activities planned for the session and the time allocated for each activity.

c. Ask if the participants have any questions.

1.2.2 Health problems of adolescents at global level

15 MIN

Objective

Discuss typical health problems and problem behaviours affecting adolescents globally.

Materials

Presentation: 1.2.2 *Health problems of adolescents: global overview*

Steps

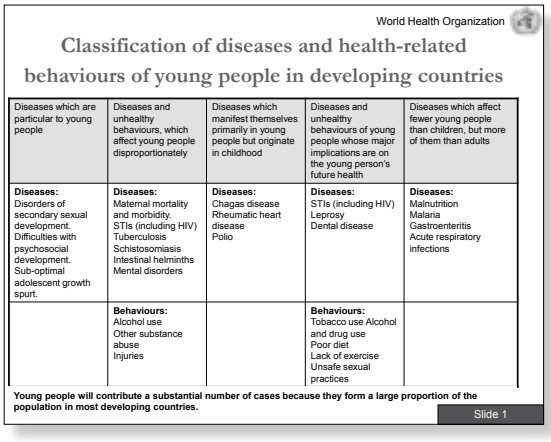
a. Explain that this presentation has two parts: a classification of health problems and problem behaviours in adolescents; and global information on the health problems of adolescents.

b. Show Presentation 1.2.2 *Health problems of adolescents: global overview*.

c. Give further explanations and examples as needed.

Talking points

Slide 1 Classification of diseases and health-related behaviours of young people in developing countries


World Health Organization

Classification of diseases and health-related behaviours of young people in developing countries

Diseases which are particular to young people	Diseases and unhealthy behaviours, which affect young people disproportionately	Diseases which manifest themselves primarily in young people but originate in childhood	Diseases and unhealthy behaviours of young people whose major implications are on the young person's future health	Diseases which affect fewer young people than children, but more of them than adults
Diseases: Disorders of secondary sexual development. Difficulties with psychosocial development. Sub-optimal adolescent growth spurt.	**Diseases:** Maternal mortality and morbidity STIs (including HIV) Tuberculosis Schistosomiasis Intestinal helminths Mental disorders	**Diseases:** Chagas disease Rheumatic heart disease Polio	**Diseases:** STIs (including HIV) Leprosy Dental disease	**Diseases:** Malnutrition Malaria Gastroenteritis Acute respiratory infections
	Behaviours: Alcohol use Other substance abuse Injuries		**Behaviours:** Tobacco use Alcohol and drug use Poor diet Lack of exercise Unsafe sexual practices	

Young people will contribute a substantial number of cases because they form a large proportion of the population in most developing countries.

Slide 1

This table divides diseases into five categories *[read out the five headings in the first row of the table].*

Column 2 shows that some diseases, such as tuberculosis, and a few health-related behaviours, such as alcohol use, have a disproportionate affect on young people.

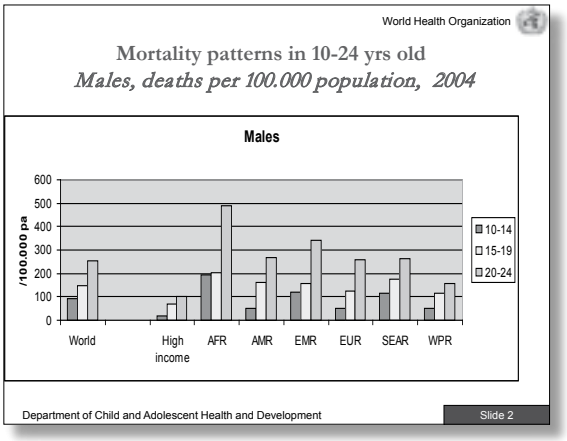
Column 3 demonstrates the importance of selected interventions in childhood, such as polio vaccination, in order to prevent illness in young people.

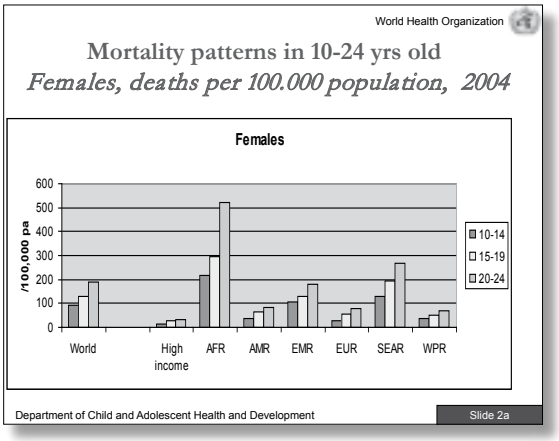
Column 4 highlights the need to promote healthy behaviours among young people, such as safe sexual practices, in order to prevent illness – such as HIV – later in life.

For many diseases listed in this table, young people will contribute a substantial number of cases, because they form a large proportion of the population in most developing countries.

We will now look at some information, from a global perspective, on the mortality and morbidity caused by these health problems and problem behaviours.

Slide 2 Mortality patterns in 10–24-year-olds



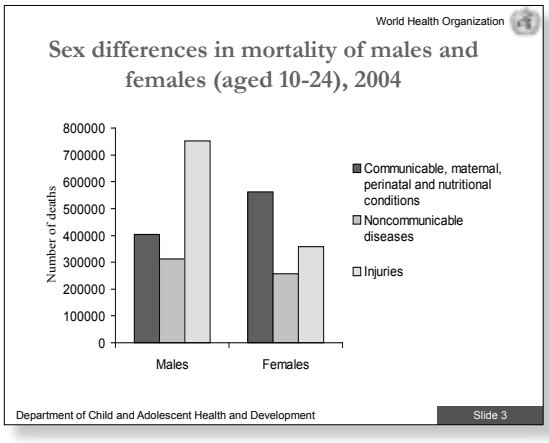


Most adolescents are "healthy"; that is, they show lower levels of morbidity and mortality compared to children and adults. Slide 2 shows how death rates in 10–24-year-old males increase with age, and differ by region. Slide 2a shows the pattern for females.

Source: WHO GPE database, 2004, http://www.who.int/whosis/mort/download/en/index.html.

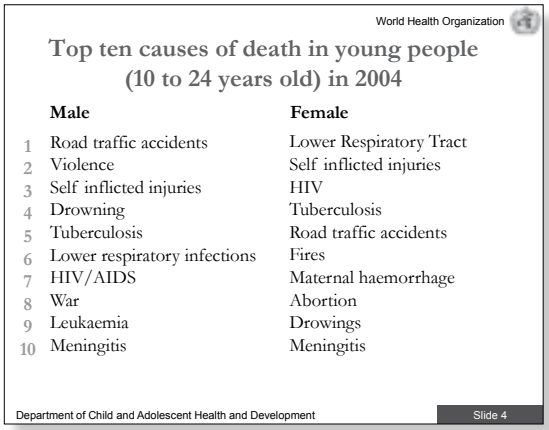
Slide 3 Sex differences in mortality of males and females (aged 10–24), 2004

This slide shows that males worldwide have higher rates of mortality from injuries (due to violence, accidents and suicide) and from noncommunicable diseases, while females have higher rates of mortality related to reproductive health problems, nutritional conditions and communicable diseases.



Slide 4 Top 10 causes of death in young people aged 10–24, 2004

This slide points to the leading global causes of deaths among young people, which include HIV-related illnesses, maternal conditions, malaria, injuries and lower respiratory tract infections. Note the significant sex differences in the causes of mortality among young people.



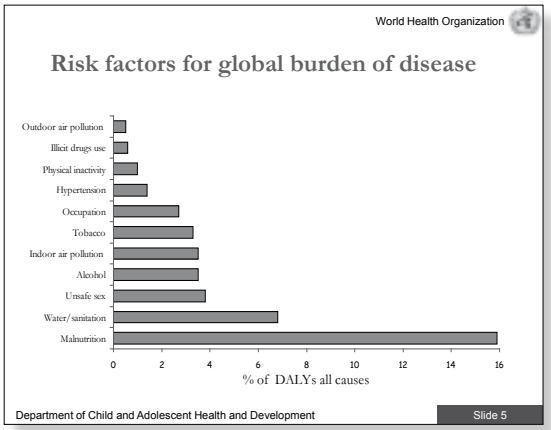
Slide 4a Worldwide mortality in young people

This overview slide provides an idea of the numbers of young people that die due to the various groupings of causes of death. These groupings – I, II and III – are standard groupings using the International Classification of Diseases (ICD-10).

Slide 5 Risk factors for global burden of disease

This slide shows 11 major risk factors for the global burden of disease. Of these, several are initiated during adolescence (e.g. use of tobacco, alcohol and other psychoactive substances, the practice of unsafe sex, and physical inactivity).

This indicates that adolescence is an important and sometimes unique window of opportunity for health promotion and disease prevention. For example, few people start smoking after age 25.



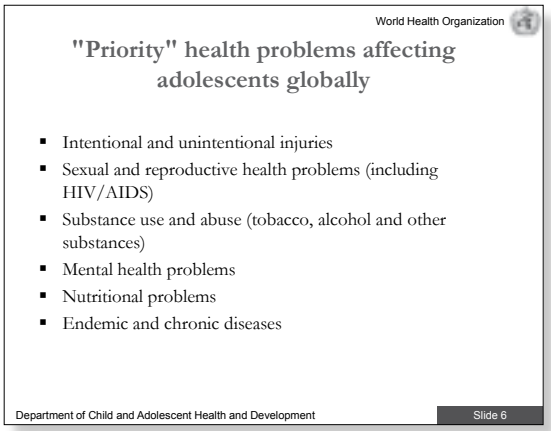
If asked what DALYs are:

For the calculation of the global burden of disease a measure called "disability-adjusted life years" or DALYs is used. One DALY is the equivalent of one healthy life year that can be lost due to death or disabling morbidities. Using DALYs allows combining suffering due to morbidities with the life years lost due to early death in one figure. DALYs have been estimated for a large number of major health conditions and the total of the DALYs lost in the whole world for all causes is referred to as the global burden of disease.

Slide 6 "Priority" health problems affecting adolescents globally

This list of "priority" health problems affecting adolescents is based on data from around the world. Each of these items meets the following three criteria:

- They cause mortality or morbidity either during the adolescent period or in later life as a result of behaviours initiated during this period.
- They cause significant levels of mortality and morbidity.
- Many of these health problems and problem behaviours are interrelated. For instance, substance use is associated with depressive states, and alcohol use is associated with road traffic accidents.



1.2.3 Problems and priorities at regional and country level

20 MIN

Objective

Discuss typical health problems and problem behaviours affecting adolescents locally.

Materials

Prepare materials needed or requested by participant presenters or guest speakers (e.g. load presentation on computer projector or overhead projector, print handouts). Participant presenters should have been provided with the handout *Guidelines for participants' presentation – Adolescent health and development: problems and priorities.*

Steps

a. Presentation on regional or country overview (10 minutes)

- Introduce the presenter.
- Explain that the presenter will give a *short overview of the health problems and problem behaviours affecting adolescents in the region (or country).*
- Tell the participants there will be a few minutes after the presentation to answer questions.
- Monitor the time, and tell the speaker when there are 2 minutes remaining.
- When the presentation is finished, ask if there are any questions.
- Allow around 2 minutes for questions, comments and discussion.

b. Presentation on country or district case study or example (10 minutes)

- Introduce the presenter.
- Explain that the presenter will give a *short introduction to a priority health problem among adolescents in their country, state or district.*
- Tell the participants that a few minutes will be given after the presentation for questions.
- Monitor the time, and tell the speaker when there are 2 minutes remaining.
- When the presentation is finished, ask if there are any questions.
- Allow around 2 minutes for questions, comments and discussion.

1.2.4 Issues to consider when developing a list of local priorities

Objective

Explain important issues to consider when developing a local list of priority health problems and risk behaviours for adolescents.

Materials

- Flipchart 10 *Local health problems and problem behaviours affecting adolescents*
- Flipchart 11 *Prioritizing health problems and problem behaviours affecting adolescents*

Steps

Overview of steps (more detailed exposition follows):

- Put up Flipchart 10 and ask the question.
- Write responses on the flipchart.
- Put up Flipchart 11 and ask the questions.
- Write responses on the flipchart.
- Encourage brief plenary discussion.

a. Put up Flipchart 10 *Local health problems and problem behaviours affecting adolescents*. Invite participants to share any information that they have, in response to the question. If you have gathered any facts and figures about the local situation, share them with the participants at this stage.

b. Ask a volunteer to write their responses on the flipchart.

FLIPCHART 10 Local health problems and problem behaviours affecting adolescents

What are the health problems affecting adolescents in your country, province, district or locality?

c. Next, display Flipchart 11 *Prioritizing health problems and problem behaviours affecting adolescents.* Stress that in preparing a list of priority health problems affecting adolescents locally, participants will need to consider questions such as those listed on this flipchart.

d. Ask a volunteer to write their responses on the flipchart.

FLIPCHART 11 Prioritizing health problems and problem behaviours affecting adolescents

Is the health problem or problem behaviour a priority for your country, province, district or locality?

Who considers it a priority and why?

How widespread is it?

e. To encourage a brief plenary discussion, ask participants: What are the issues that need to be considered when developing a local list of priority health problems and risk behaviours for adolescents?

f. Conclude by highlighting that the participants do not need to come up with a list of priority health problems as part of this exercise, but that it is important for ministries of health to do so in conjunction with other relevant stakeholders within and outside the government, and to involve adolescents in the priority-setting work.

Session 1.3 Adolescent rights, diversity and vulnerability

Agenda for adolescent rights, diversity and vulnerability	
00:05	1.3.1 Introduction
00:40	1.3.2 Human rights: characteristics and principles
00:45	1.2.3 Problems and priorities at regional and country level
00:30	Break
00:35	1.3.4 Diversity and vulnerability
00:15	 Participants' presentation time (optional)
02:20	

Note to facilitator

Participants should be carefully guided through the session, particularly in light of the limited time available. The session is crucial for helping participants to reflect on the value of addressing adolescent health in terms of adolescents' rights rather than needs.

Session objectives

By the end of this session participants will be able to:

- Explain the characteristics and principles of human rights;
- Describe how human rights can guide health planners to better address vulnerable populations;
- Explain how different subpopulations of young people are at different risk for health problems;
- Discuss how vulnerable groups may not have equal access to preventive and curative services.

Preparation

Presentations

- 1.3.2 *Human rights: characteristics and principles*
- 1.3.3 *Duty bearers: who has a responsibility to act?*

Flipcharts

- Flipchart 12 *Which groups are at risk?*
- Flipchart 13 *List of health issues*

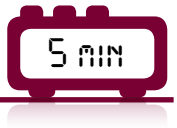
Handouts

- 1.3.3 *Adolescents and the Convention on the Rights of the Child (CRC) (General Comment No. 4)*
- 1.3.3 *CRC case studies: the relevance of human rights to adolescent health and development*
- 1.3.3 *The CRC and health*

Other materials

Three VIPP cards with feedback headings: high, intermediate and low

1.3.1 Introduction



Materials

Handout: *Five-day agenda*

Steps

a. Introduce the session objectives using the handout.

b. Explain the activities planned for the session and the time allotted for each activity.

c. Encourage participants to ask questions and raise concerns during the session.

d. Remind participants about the *Matters arising* board and encourage them to use it during breaks.

e. Ask if there are any questions.

1.3.2 Human rights: characteristics and principles

Objective

Explain the characteristics and principles of human rights.

Note to facilitator:

During this interactive presentation, you will need to ensure that all participants are involved in the discussion. To improve participation, you may:

- ask questions to specific participants (using their names)
- repeat responses
- encourage interaction between the participants
- ask for more information, for example:
  - "Does anyone have something to add to this?"
  - "Abdul, would you share your thoughts on … ?"
  - "Leyla, what is your opinion?"
  - "Michelle, do you agree with the statement that … ?"
  - "Juan, could you explain a little more clearly what you mean by … ?"
- restate a question and direct it to another participant
- summarize key points of the discussion periodically, by asking, "any additions?"

Materials

Presentation: 1.3.2 *Human rights: characteristics and principles*

Steps

a. Introduction (5 minutes)

- Ask if any of the participants have heard of the United Nations Convention on the Rights of the Child, or CRC? Ask those who have heard of it to raise their hand.
- Ask if someone could describe the CRC. What is the purpose of the convention?
- Wait for a response. If someone responds, summarize what they have said and thank them for their participation.
- Explain that the CRC provides a holistic normative and legal framework not only for dealing with the rights of children, but also for addressing a broad range of adolescent health and development needs. According to the convention, a child is every human being below the age of 18 years unless under the law applicable to the child, majority is attained earlier.
- Explain that during this exercise we will discuss the underlying *characteristics* and *principles* of the CRC that help to make the Convention a useful legal framework for enhancing the health sector response to the needs of adolescents.
- Ask a volunteer to come to the front of the room to help you note important points from the discussion on a blank piece of flipchart paper.

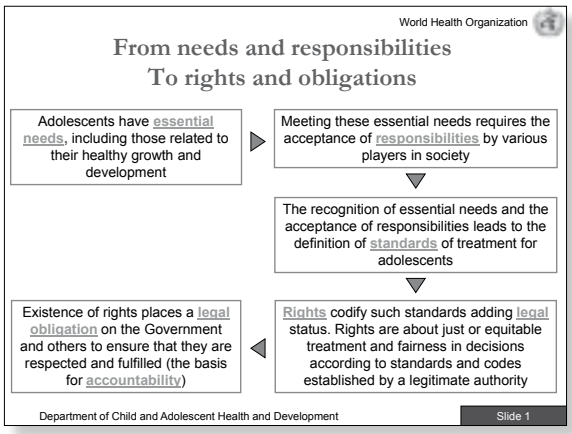
b. Interactive presentation (35 minutes)

Talking points

Slide 1 From needs and responsibilities to rights and obligations

This slide illustrates the transition from adolescents' needs and associated responsibilities to adolescents' rights and associated legal obligations.

- "Responsibility" does not entail a binding duty to take action.
- "Obligation" entails a requirement to action.
- "Legal obligation" means action is required by law; in other words, it is a legal requirement to take action.
- The acceptance of legal rights brings with it the acceptance of legal obligations to ensure that such rights are being respected, protected and fulfilled.

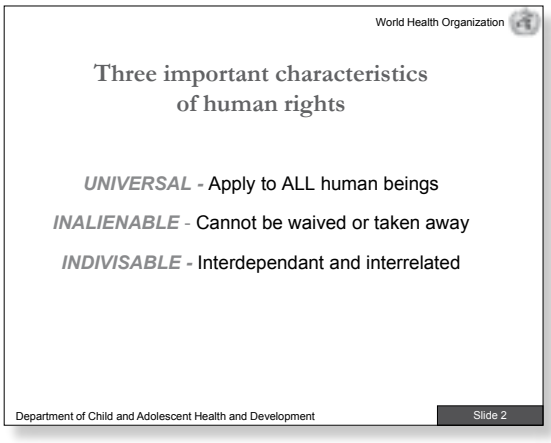


Slide 2 Three important characteristics of human rights

Human rights have underlying characteristics. The three most important characteristics are:

- Human rights are *universal.* They apply to *all* human beings.
- They are *inalienable.* They cannot be waived or taken away.
- They are *indivisible.* They are interdependent and interrelated.

Now let's look at a few examples of how these characteristics apply in different situations.

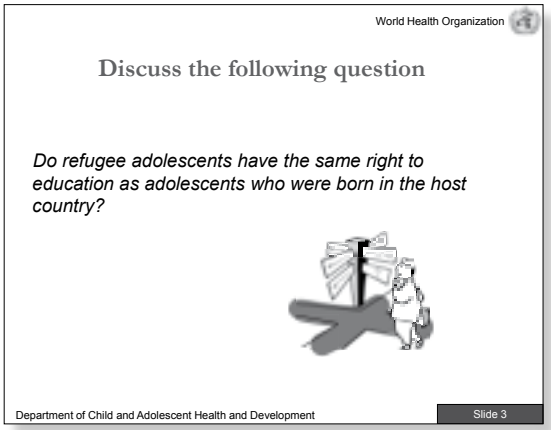


Slide 3 Discuss the following question

Do refugee adolescents have the same right to education as adolescents who were born in the host country?

Example questions

- How would you answer this question?
- Does everyone agree?
- Why?



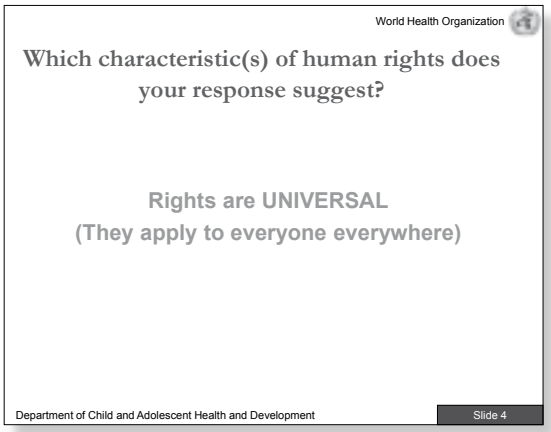
Slide 4 Which characteristic(s) of human rights does your response suggest?

If we look back at the underlying characteristics of human rights, which characteristic does this example illustrate? [Answer: Rights are *universal*]

The right not to be discriminated against – a basic tenet of all human rights – covers *all* differences among adolescents – sex, race, religion, economic status, etc. It is a crucial factor not only in planning services but also in influencing social values.

Question

- What is another example of a situation where the characteristic of *universality* would apply?

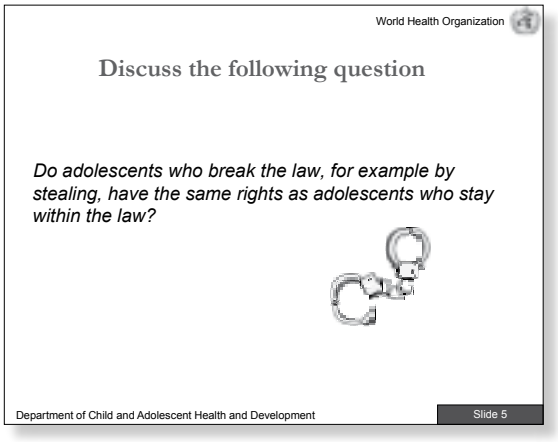


Slide 5 Discuss the following question

Do adolescents who break the law, for example by stealing, have the same rights as adolescents who stay within the law?

Example questions

- How would you answer this question?
- Does anyone have another opinion?
- Why?

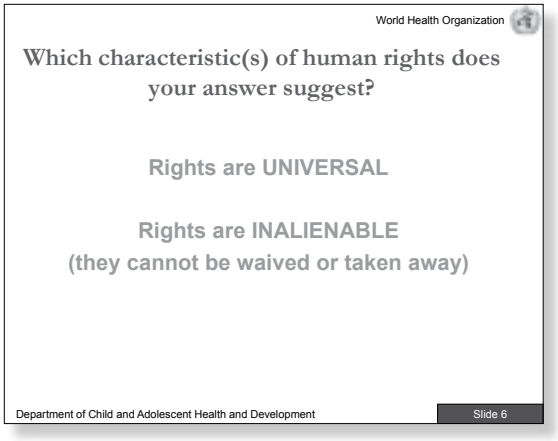


Slide 6 Which characteristic(s) of human rights does your answer suggest?

Which characteristics of human rights does this example illustrate? [Answer: Rights are *universal*. Rights are *inalienable*.]

Even if an adolescent breaks the rules of society, the adolescent is still entitled to *all* of his or her rights. Rights cannot be lost or earned. They apply to all adolescents all the time.

The basic underlying concept of all human rights is that the individual has rights simply because he or she is human. Everything else stems from that.



This characteristic is very important when looking at marginalized children, and children in especially difficult circumstances, such as child soldiers. In these situations, there is a wide difference between society's expectations of the child and the child's actual lifestyle or actions. For example, societies may see children as individuals who do not kill, but they are faced with the fact that some children are combat soldiers. In such circumstances, society may find it difficult not to treat them as having different rights.

By denying certain individuals their human rights, a society is effectively downgrading their humanity. If society classes some individuals as inferior, or "subhuman", it can justify maltreatment. History is full of examples of this.

Question

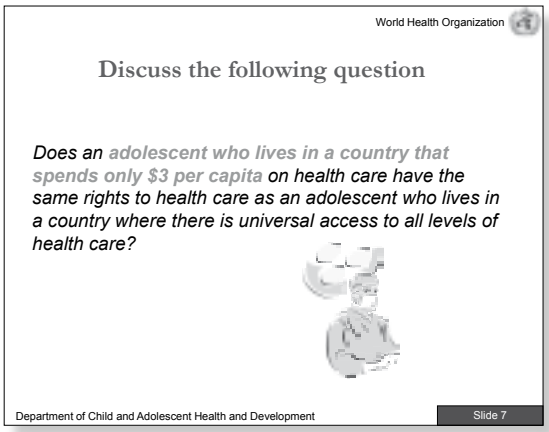
What is an example of another situation where the *inalienable* characteristic of human rights would apply?

Slide 7 Discuss the following question

Does an adolescent *who lives in a country that spends only US$3 per capita on health care* have the same rights to health care as an adolescent who lives in a country where there is universal access to all levels of health care?

Example questions

- What do we mean by right to health care?
- Do all people have the same right to health care?
- Why?

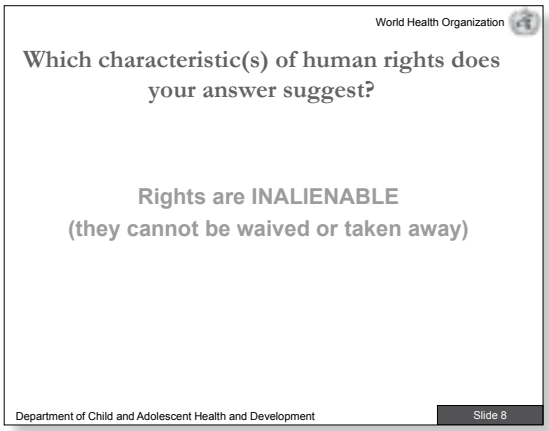


Slide 8 Which characteristic(s) of human rights does your answer suggest?

Which characteristic(s) does this example illustrate? [Answer: Rights are *inalienable*.]

The existence of a right does not depend on the circumstances in which an adolescent lives. A right still exists, even if circumstances make it difficult for the right to be realized.

Sometimes a wide gulf exists between the ideal situation described by human rights conventions and the actual situation of many adolescents. Very few adolescents actually achieve all the rights to which they are entitled. In many countries, the social or economic situation makes it very difficult or impossible for all rights to be realized.



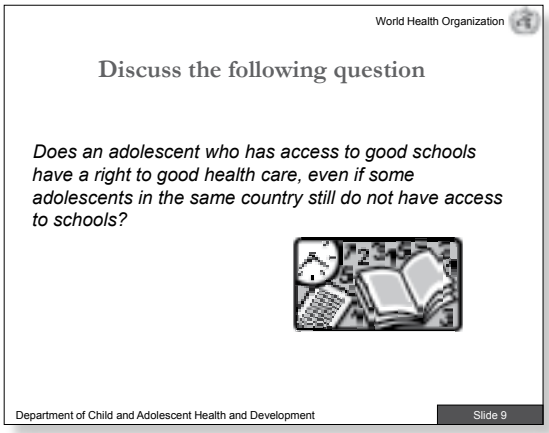
This does not change the entitlement of the adolescent to the rights. Remember that rights express the standards of treatment that societies would like to apply to their adolescents – even if they cannot do it immediately. The value of human rights lies in their ability to provide a framework for thinking about future development.

Slide 9 Discuss the following question

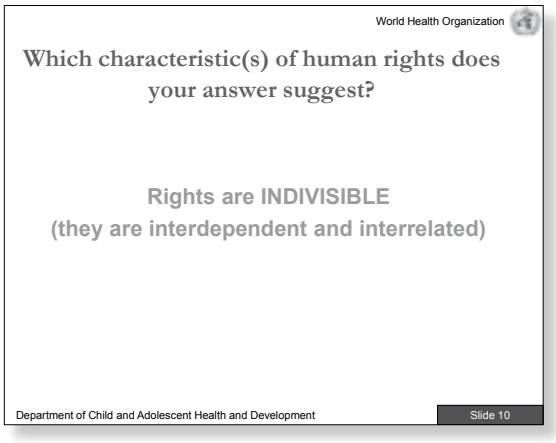
Does an adolescent who has access to good schools have a right to good health care, even if some adolescents in the same country still do not have access to schools?

Example questions

- Should *all* adolescents have access to good schools first, before they can have access to health care?
- Does anyone have another opinion?
- Why?



Slide 10 Which characteristic(s) of human rights does your answer suggest?



Which characteristic(s) does this example illustrate? [Answer: Rights are *indivisible.*]

Even though some rights may be achieved before others, *all* adolescents have *all* the rights *all* the time.

The framework of human rights touches on almost every aspect of human life. Human rights conventions express the ideal that all people should have all these rights. The practical implication of this is that the analysis of an adolescent's situation cannot be limited only to one aspect of the adolescent's life. A "rights-based" approach to the adolescent leads us to a much broader vision of the adolescent's needs, the factors underlying any immediately apparent problems and the actions that can be brought to bear on them.

In many social and economic circumstances, effective and full realization of human rights may be extremely difficult to achieve. Nevertheless, nobody should claim that human rights are only important to consider in situations of political and economic stability and prosperity.

You will see this in the case studies in the next exercise.

Slide 11 Key human rights principles

Four overarching principles are stated in the Convention on the Rights of the Child and help to guide its implementation:

- Equality and non-discrimination
- Progressive realization
- Participation and inclusion
- Accountability and the rule of law.

Questions

- What do these principles mean?
- How might they affect health planners?
- In what ways are they relevant to health service provision?

- Emphasize that human rights characteristics and principles can guide health planners to better address adolescent health and development.
- Thank the participants for sharing their thoughts and opinions.

1.3.3 Relevance of human rights to adolescent health

45 MIN

Materials

- Handout: 1.3.3 *The CRC and health*
- Handout: 1.3.3 *Adolescents and the Convention on the Rights of the Child (General Comment No. 4)*
- Handout: 1.3.3 *CRC case studies: the relevance of human rights to adolescent health and development* (one copy for each participant)
- Presentation: 1.3.3 *Duty bearers: who has a responsibility to act?*

Steps

a. Introduction (15 minutes)

- Distribute the handout *The CRC and health.*
- Briefly go through the handout with the participants.
- Distribute the handout *Adolescents and the Convention on the Rights of the Child (General Comment No. 4)*. Let participants study how in each section reference is made to a variety of articles.
- Ask if there are any questions.

b. Group exercise (20 minutes)

- Distribute the handout *CRC case studies: the relevance of human rights to adolescent health and development*.
- Tell the participants that they will divide into groups to explore a case study from *CRC case studies: the relevance of human rights to adolescent health and development* (either "Rowena" or "Alia").
- Explain that each group should review the case study they are assigned and identify which rights are relevant to the case study, and which rights are not being met.
- Explain that the groups will have 15 minutes to complete the exercise and write their points on a flipchart.
- Ask if there are any questions.
- Divide participants into groups by counting off individuals in turn: 1, 2, 3, etc. All "ones" will form a group, the "twos" a second group, and so on.
- Assign each group one of the two case studies.
- Ask the groups to move to different parts of the room and start working.
- After 15 minutes, ask the groups to stop working, and to move back to plenary.

c. Plenary feedback (10 minutes)

- Ask one group to read out the case study they were assigned, and then report which rights were relevant to the story and why.
- As the group presents, write their findings on a blank flipchart, headed "Rowena" or "Alia".
- Ask the other groups to present.
- Invite other participants to add to the flipcharts.
- Show the following slides.

Talking points

Slide 1 Duty bearers: who has a responsibility to act?

The term "duty bearer" is a legal, human rights term.

Human rights determine the relationship between individuals and groups with valid claims (rights holders) and State and non-State actors with obligations (duty bearers).

Using this approach one can identify rights holders (and their entitlements) and corresponding duty bearers (and their obligations) and work towards strengthening the capacities of rights holders to make their claims, and of duty bearers to meet their obligations.

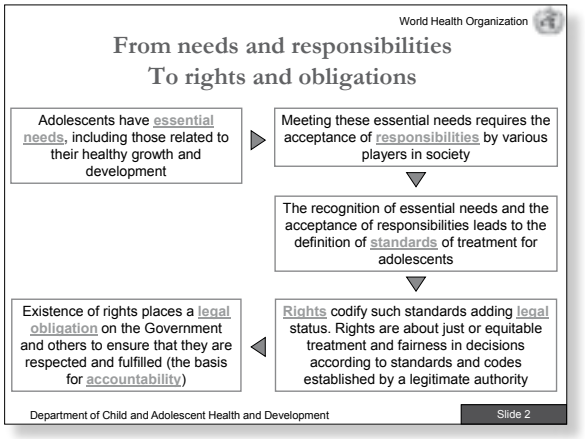
The growing international legal system sets the context for a rights-based approach to development by placing human rights laws at the centre of development practice. Under this system, the population, or rights holders, have the right to demand from the duty bearer, which is often the State, that it meets its obligations under international law to respect, protect and fulfil people's rights.

The duty bearer can also be a private entity such as a corporation, a family or a local government.

Questions

- In these case studies, who where the duty bearers?
- Can you give some examples of their obligations to ensure that the girls' rights are met?

Slide 2 From needs and responsibilities to rights and obligations



As we discussed in the previous exercise, the rights approach allows us to approach adolescent health and development problems from a different perspective.

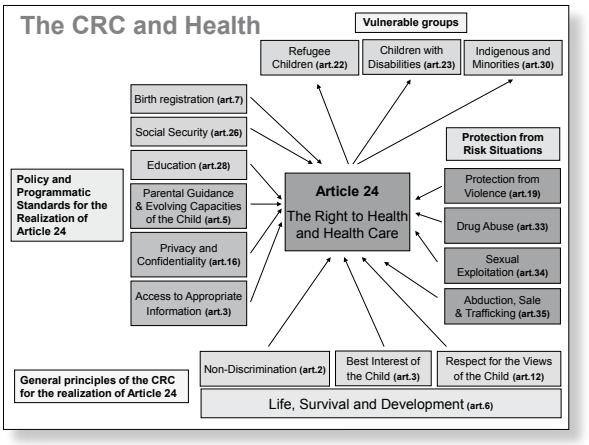
Ask someone to remind everyone of the difference between responsibilities and obligations.

Slide 3 The CRC and health

Recap how in the handout we've seen that many CRC articles – not only article 24 – are relevant for the health of adolescents.

Show the four groupings of articles that complement article 24 in the CRC.

Optional: Make the link from the CRC to other rights frameworks also relevant to adolescents, such as the right to health, and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW).



- Explain that this exercise should help participants reflect on the value of addressing adolescent health in terms of adolescents' rights rather than just needs.
- Thank the participants and ask if there are any questions.

1.3.4 Diversity and vulnerability

35 MIN

Objectives

Explain how different subpopulations of young people are at different risk for health problems.

Discuss how vulnerable groups may not have equal access to preventive and curative services.

Materials

- Flipchart 12 *Which groups are at risk?*
- Flipchart 13 *List of health issues*
- Three VIPP cards with feedback headings: "high", "intermediate" and "low"

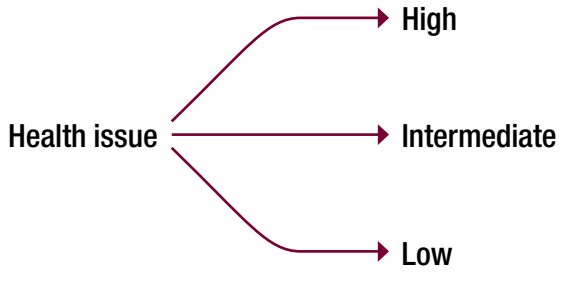
Steps

a. Introduction (5 minutes)

- We often think of adolescents or young people as one group of people, like we think about children under 5.
- However, adolescents are not all the same. For example, a 10-year-old boy is very different, and may have different needs, from an 18-year-old girl.
- Adolescent boys, as a group, have different needs from adolescent girls.
- At the same time, there are groups of adolescents who, primarily for social reasons, are particularly vulnerable.
- Ask the group to identify some groups of young people they think of as "vulnerable". You can give examples such as children living in the street or adolescents who are involved in dangerous professions (this may include sex work). Explain that such groups face a variety of challenges, both social (such as exclusion) and health-related (for example, sexually transmitted infections for sex workers, drug dependence for street children).
- In the exercise that follows, we will identify groups that are more vulnerable than others by looking at some specific health issues.

- For a particular health issue, one group of adolescents may be at high risk, while other groups are at intermediate or low risk.
- Show Flipchart 12 *Which groups are at risk?*

FLIPCHART 12 Which groups are at risk?



- We can think about the top 10 causes of death among adolescents, which we discussed earlier today, and use the issue of road traffic accidents as an example.
  - Which groups of adolescents are at *high risk* for road traffic accidents?
  - Which are at *intermediate risk*?
  - Which are at *low risk*?
- Write "road traffic accidents" above the words "health issue" on the flip chart. Then write the name of a high-risk group next to the word "high"; the name of an intermediate-risk group next to the word "intermediate"; and the name of a low-risk group next to the word "low".

b. Buzz group exercise (15 minutes)

- Tell the participants that they will divide into six small buzz groups with the participants around them to explore six different health issues.
- Show a flipchart with the following health issues:

FLIPCHART 13 List of health issues

1. *Contract HIV infection*
2. *Unwanted pregnancy*
3. *Contract a sexually transmitted infection*
4. *Suffer complications and die during childbirth*
5. *Undergo an unsafe abortion*
6. *Work-related accidents*

- Explain that each buzz group will be assigned one health issue from the list. The buzz group should identify one group of adolescents who are at high risk, one group at intermediate risk and one group at low risk for their assigned health issue.
- They should describe the group at risk of their health issue and write “high”, “intermediate” or “low” risk on three separate VIPP cards.
- In addition, they should discuss to what extent (or degree) each of the groups (high, intermediate and low) has access to health information and services to prevent or treat the health issue.
- Divide the participants into six buzz groups with their neighbours.
- Assign each group a health issue from the list above.
- Give each group three VIPP cards and a marker pen.
- Explain that the groups have 5 minutes to complete the exercise.
- After 5 minutes, ask the groups to stop.

Instructions for group work (buzz groups): session 1.3.4

- *Each buzz group will be assigned one health issue from the flipchart. The buzz group should identify one group of adolescents who are at high risk, one group at intermediate risk and one group at low risk for their assigned health issue.*
- *In addition, discuss to what extent (or degree) each of the groups (high, intermediate and low) has access to health information and services to prevent or treat the health issue.*
- *You have 5 minutes to complete the exercise.*

c. Feedback from buzz groups (15 minutes)

- As each group presents, place their cards under the headings “high”, “intermediate” and “low” risk.
- Discuss with the participants to what extent the groups written on the cards have access to health information and services to prevent or treat the health issue.
- End the activity.

Participants’ presentation time (optional)

Session 1.4 Why invest in adolescents?

Agenda for why invest in adolescents?	
00:05	1.4.1 Introduction
00:25	1.4.2 Debate
00:10	1.4.3 Plenary review
00:40	

Session objective

By the end of this session participants will be able to present important reasons for investing in adolescent health and development.

Preparation

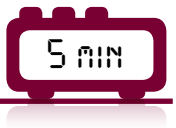
Presentation

- 1.4.3 *Main reasons for investing in adolescent health and development*
- Flipchart 14 *Debate statement*

Other materials

Two VIPP cards with “arguments for” and “arguments against”

1.4.1 Introduction



Materials

Handout: *Five-day agenda*

Steps

a. Introduce the session objectives using the handout.

b. Explain the activities planned for the session and the time allocated for each activity.

c. Ask if the participants have any questions.

1.4.2 Debate

25 MIN

Materials

- Flipchart 14 *Debate statement*
- Two VIPP cards with "arguments for" and "arguments against"

Steps

a. Explain that you would like the participants to debate an important statement.

b. Show Flipchart 14 and read the statement aloud.

FLIPCHART 14 Debate statement

"It is essential that national and local health leaders, planners and managers pay particular attention to adolescent health."

c. Explain that you would like one group to prepare a set of arguments "for" the statement, and another group to prepare a set of arguments "against" it.

d. Divide the participants by counting off (1, 2, 1, 2 …), and allocate one group "for" and the other "against".

e. Ask each group to quickly decide on a presenter and to prepare at least three strong arguments. They should write the key words on three VIPP cards.

f. Ask the two groups to move to different sides of the room and begin working. Tell them that in 5 minutes you will ask them to be ready to argue their case.

g. When the time is up and everyone is ready, ask the two groups to return to plenary.

h. Ask the presenter from the "against" group to come forward. The presenter should put up the three VIPP cards under the "arguments against" column and explain.

i. Ask three volunteers from the "for" group to offer one effective counter-argument against each of the statements written on the three VIPP cards.

j. On a blank flipchart write the counter arguments under a "for" column.

k. Ask the presenter from the "for" group to come forward. The presenter should put up the three VIPP cards under the "arguments for" column and explain.

l. Immediately after the volunteer from the "for" group has finished speaking, encourage three volunteers from the "against" group to debate the points by offering one argument against each new statement written in the "for" column.

m. On the flipchart write the counter-arguments under an "against" column.

1.4.3 Plenary review

10 min

Materials

Presentation: 1.4.3 *Main reasons for investing in adolescent health and development*

Steps

a. When all the arguments from both sides have been presented and countered, briefly summarize the debate and stress that there will always be arguments on both sides.

b. Point out that it is important for the participants to be fully aware of the public health rationale for investing in adolescents. Stress that the participants must have the data (facts and figures) at hand to support their arguments and must press for attention and investment in adolescent health and development.

c. Very few people ask *why* it is important to invest in child health, because the immediate benefits of doing so are apparent. The need to invest in adolescent health is not always so immediately apparent.

d. Show the following slide, which presents three main reasons for investing in adolescent health.

Talking points

Slide 1 Main reasons for investing in adolescent health and development

Investing in the health of adolescents will reduce the burden of disease during this stage and in later life. It is during adolescence that behaviours are formed, which often last a lifetime.

The HIV pandemic alone is sufficient reason to look anew at how health services address the needs of adolescents. Over 50% of new HIV infections occur among persons under the age of 25.

Smoking, which often begins during adolescence, will lead to an estimated 150 million tobacco-related deaths during adulthood.

Further, what adolescents do today will have an influence on their health as adults and on the health of their children (intergenerational effects).

Promoting and protecting adolescent health is an excellent short- and long-term investment.

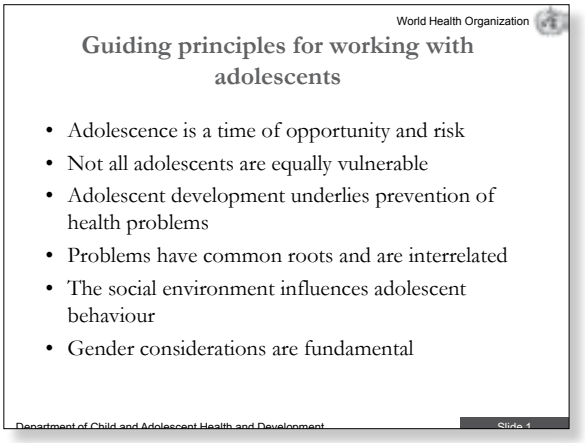
Improvements in the health of adolescents will increase their achievements in school and will lead to greater productivity.

As discussed earlier, the CRC declares that young people have a right to life, development and, in article 24, "The highest attainable standard of health, and to facilities for the treatment of illness and rehabilitation of health". The CRC is ratified by almost every country in the world.

Now we will look at the last two slides of the day, which outline the guiding principles and approach in our work with adolescents.

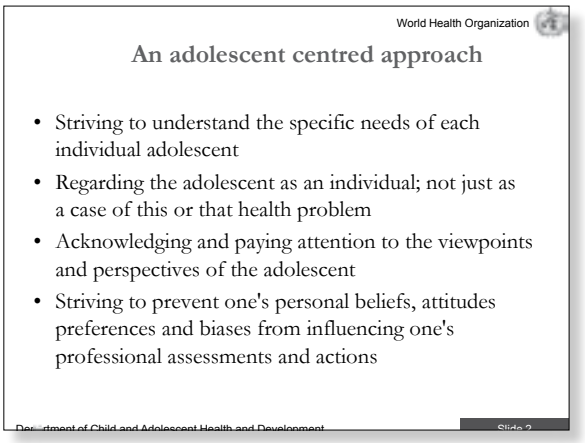
Slide 2 Guiding principles for working with adolescents

Read the slide aloud and where appropriate make the links to topics, discussions and exercises the participants carried out during the day.



Slide 3 An adolescent-centred approach

(Read out the slide. Ask if there are any comments or questions.)



Finally, thank the participants for their work today and ask if there are any questions.

Session 1.5 Day 1 wrap-up

15 min

Materials

Flipchart 15 *Personal diary questions*

Steps

a. Ask participants to open the book that they will use as their personal diary.

b. Go through the two points on the flipchart (this same flipchart will be used for wrap-up on days 2, 3 and 4).

FLIPCHART 15 Personal diary questions

1. *What did you find particularly useful today? List up to three things.*

2. *List three things you would like to do (differently) in your day-to-day work as a result of what you learnt today.*

c. Ask if there are any questions.

d. Ask them to write their responses in their diary.

e. Refer participants to the agenda for day 2 to prepare them for tomorrow.

f. Thank the participants for their hard work today and say we will begin again at 8:30 tomorrow morning.

Day 1 Handouts:

- Five-day agenda
- *Session 1.1.3* Instructions for group work
- *Session 1.1.3* Changes that occur during adolescence
- *Session 1.2.2* Guidelines for participants' presentations
- *Session 1.3.3* The CRC and health
- *Session 1.3.3* Adolescents and the Convention on the Rights of the Child (CRC) (General Comment No. 4)
- *Session 1.3.3* CRC case studies: the relevance of human rights to adolescent health and development
- *Sessions 1.3.4* Instructions for group work

Five-day agenda

Time	Day 1: Introduction to adolescent health and development	Day 2: Programming for adolescent health and development using the MAPM framework	Day 3: Strategic approaches for addressing priority health and development issues	Day 4: Scaling up health service provision and strengthening other sectors	Day 5: Supportive policies and final planning
08:30–10:00	Inauguration Course introduction	Administrative issues, flashback and agenda for day 2 **2.1 Introduction to the Mapping Adolescent Programming and Measurement (MAPM) framework**	Administrative issues, flashback and agenda for day 3 **3.1 Global goals and targets** **3.2 Strategic framework for programming**	Administrative issues, flashback and agenda for day 4 **4.1 Introduction to scaling up health service provision to young people**	Administrative issues, flashback and agenda for day 5 **5.1 Supportive evidence-informed policies**
10:00–10:30	*Break*				
10:30–13:00	**1.1 Understanding young people, with a focus on adolescents** **1.2 Global and regional overview**	**2.2 Using the MAPM framework to design or review programmes** **2.3 A closer look at determinants**	**3.2** (continued) **3.3 The role of the health sector** **3.4 Strategic information**	**4.1** (continued) **4.2 Making health services friendly for young people**	**5.1** (continued)  Participants' presentation time **5.2 Planning for HIV and reproductive health programmes II**
13:00–14:00	*Lunch*				
14:00–15:30	**1.3 Adolescent rights, diversity and vulnerability**	**2.3** (continued)  Participants' presentation time	**3.4** (continued)  Participants' presentation time **3.5 Strategic information for programme monitoring and evaluation**	**4.2** (continued)  Participants' presentation time	**5.3 Evaluation of the course** **5.4 Closing**
15:30–16:00	*Break*				
16:00–17:45	**1.3** (continued)  Participants' presentation time **1.4 Why invest in adolescents?** **1.5 Day 1 wrap-up**	**2.4 planning for HIV and reproductive health programmes I** **2.5 Day 2 wrap-up**	**3.5** (continued)  Participants' presentation time **3.6 Day 3 wrap-up**	**4.3 Strengthening other sectors** **4.4 Day 4 wrap-up**	

HANDOUT

Session 1.1.3 Instructions for group work

You will be divided into three groups.

Appoint a rapporteur for your group, who will fill in the flipchart and report back to the group in plenary.

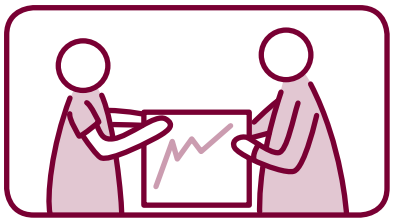
- Each group will identify events or changes in adolescence that occur in each of these categories: *physical, psychological* and *social.* Each group will work on a different stage of adolescence (early, middle and late adolescence).
- Each group will identify up to three changes or events for each of the three categories: *physical* changes and events, *psychological* changes and events, and *social* changes and events. Some of the changes and events you identify will overlap in the three categories.
- Think about whether the events or changes you identify relate to male adolescents, female adolescents or to both.
- You have 15 minutes to complete your part of the table.

Session 1.1.3 Changes that occur during adolescence

Category of change	Early: 10–15 years	Middle: 14–17 years	Late: 15–19 years
Growth of body	Secondary sexual characteristics appear Rapid growth reaches a peak	Secondary sexual characteristics advanced Growth slows down Has reached approximately 95% of adult growth	Physically mature
Growth of brain (prefrontal cortex)	Brain growth occurs Impacts on social skills and problem solving		
Cognition (ability to get knowledge through different ways of thinking)	Uses concrete thinking ("here and now") Does not understand how action now has results in the future	Thinking can be more abstract (theoretical) but goes back to concrete thinking under stress Better understands results of his/her action Very self-absorbed	Most thinking is now abstract Plans for the future Understands how choices and decisions now have an affect on the future
Psychological and social	Spends time thinking about rapid physical growth and body image (how others see him/her) Frequent changes in mood	Creates their body image, focus on appearance Thinks a lot about impractical or impossible dreams Feels very powerful Experimentation – sex, drugs, friends, risks	Plans and follows long-range goals Realistic body image, usually comfortable with body image Understands what they consider is right and what is wrong (morally and ethically)
Family	Struggling with rules around independence/dependence Argues and is disobedient	Argues with people in authority	Moving from a child–parent/guardian relationship to more equal adult–adult relationships
Peer group	Important for their development Intense friendships with same sex Contact with opposite sex in groups	Strong peer friendships Peer group most important and determines behaviour	Decisions/values less influenced by peers in favour of individual friendships Selection of partner based on individual choice rather than what others think
Sexuality	Self-exploration and evaluation Preoccupation with romantic fantasy	Forms stable relationships Testing how he/she can attract others Sexual drives emerging	Mutual and balanced sexual relations Plans for future More able to manage close and long-term sexual relationships

Source: Adapted from the *Orientation Programme on Adolescent Health for Health-Care Providers*, WHO, 2003.

Session 1.2.2 Guidelines for participants' presentations



Adolescent health and development: problems and priorities

You have been asked to present a brief overview of the problems and priorities related to adolescent health and development in your region, country or district. Please use the checklist below to help you prepare the presentation.

Your 5–10 minute presentation should include:

- an introduction to the priority health problem(s) or problem behaviour(s) affecting adolescents in your area
- obstacles and challenges to addressing the problem(s)
- progress and opportunities
- next steps for the future.

Note: If you use PowerPoint slides or overheads, please limit the number of slides you present to five.

Checklist on adolescent health and development

What information do we have about adolescents in the district, country or region?

- Demographic data, broken down by age group and sex.
- Socioeconomic status (including opportunities for and levels of education, opportunities for and levels of employment, family and social support, and access to basic necessities such as clean water, food and shelter).
- Health status (including the leading causes of disease and death).
- Groups and subgroups of adolescents who are especially vulnerable to health and social problems (for example those who live and work on the street).

What information do we have about the health services that are available to and used by adolescents?

What information do we have about:

- existing laws and policies relating to the health and development of adolescents (e.g. the age of consent to sexual intercourse, access to contraception)?
- principles and practices of national institutions, such as national medical associations, that affect the availability and accessibility of health information and services for adolescents (such as confidentiality in the context of sexual and reproductive health)?

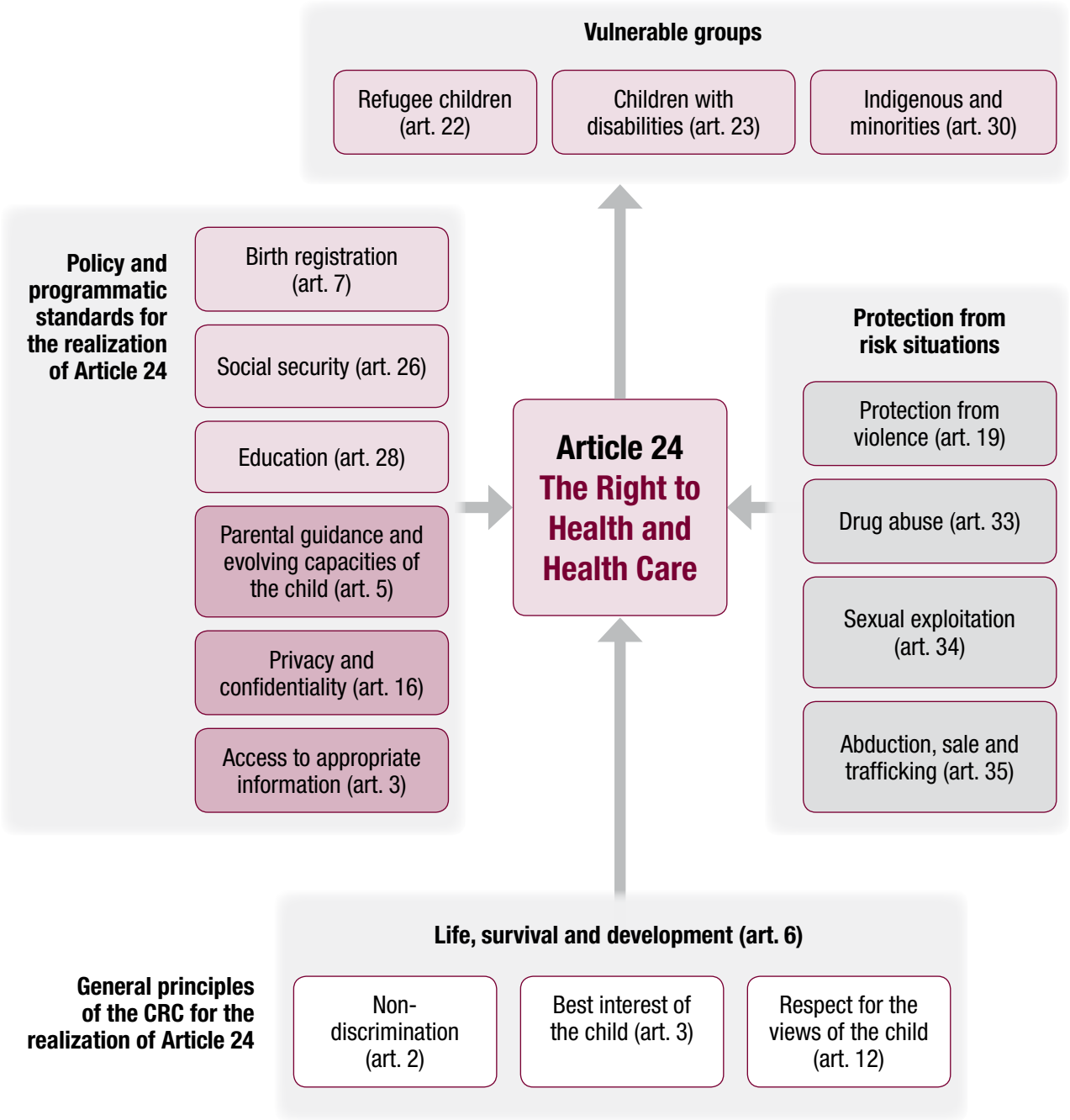
What information do we have about ongoing actions to promote and safeguard the health of adolescents, and to help them develop into well-adjusted adults?

- Which government departments carry out, or support, programmes in this field at the national level?
- What are the responsibilities of provincial or district-level government departments in this field, and what mechanisms are in place?
- Which nongovernmental organizations carry out or support activities in the field, at national, provincial and district levels?

HANDOUT

Session 1.3.3 The CRC and health

The UN Convention on the Rights of the Child (CRC) is a normative and legal framework for addressing child and adolescent health



The Convention on the Rights of the Child (CRC) is the principal international human rights treaty that sets out the particular rights of children and adolescents up to the age of 18. It was formulated in recognition of the fact that children and adolescents, like all other human beings, are entitled to human rights, but that the special features of children and childhood deserve particular protection beyond that provided for in the Universal Declaration of Human Rights. The CRC took 10 years to prepare and was finally adopted by the United Nations General Assembly in 1989. It has been ratified by 192 of the 194 United Nations Member States. The CRC is an instrument with international legal force, and the governments that have ratified it have an obligation to abide by its provisions.

Broad scope of the CRC

The CRC is based on a deep and internationally recognized understanding of the needs of children and adolescents. Thus, the scope of the CRC is broad; it considers children's civil rights and freedoms (such as their right to a name and nationality, and to access to appropriate information), and issues related to their family environment and other forms of care. It has articles that refer to health, education, leisure and cultural activities, and those that refer to groups of children and adolescents who may be in need of special protection.

Perhaps most importantly, the CRC sets out some *general principles* that should guide all activities directed towards children and adolescents, including those in the field of child and adolescent health and development. These general principles are that:

- each child has the right to survival and to development;
- all children shall be treated without discrimination;
- the child's best interests should be the primary consideration in actions undertaken on his or her behalf;
- the child's views should be taken into account in matters that affect him or her, being given due weight in accordance with his or her age and maturity.

All the other articles of the CRC should be understood and implemented in the light of these principles.

The CRC and health

The CRC is a vital tool for those who work towards improving the conditions of life for children and adolescents throughout the world. For those working for the health of children and adolescents, its health-related articles provide guidance about the aims of services and the kinds of provisions that might be made. Other articles within the CRC are equally important because they define the approach that should be adopted in all activities that are directed towards the well-being of children and adolescents.

Throughout the range of issues that the CRC addresses, the health of children and adolescents is an important concern. Although there is a particular article that refers to health, article 24, this is only one of the ways in which the health-related needs and rights are addressed in the CRC. Failing to respect, protect and fulfil the rights of children and adolescents in so many domains will obviously have an adverse impact on health. As an illustration, girls who are unable to go to school have a much higher chance of early pregnancy and the associated complications. Furthermore, recognizing the general principles of the CRC in matters related to the health of children and adolescents is a prerequisite for fulfilling their health-related rights.

The right to health, laid out in article 24, focuses on the practical application of the principle set out in article 6.

Article 24 is much more specific about what is meant by the "right to health" than the equivalent articles in the other human rights instruments. Article 24 considers the right to health and to health care together, given their complementary nature. The article emphasizes that primary care is particularly important, and it sets out specific health goals that are particularly related to child survival. The wording of the article makes it clear that this is not an exclusive list of goals or provisions. The article refers to traditional practices harmful to health, but it leaves open the definition of what these are. Practices such as female genital mutilation and early marriage might be considered here.

Provision for a child's welfare accompanies efforts made towards assuring a child's health. Articles 26 and 18(3) relate to ensuring that social security benefits and child-care facilities are available for a child.

The CRC recognizes that children are also in need of protection from risks that are immediately harmful to health. Children have a right to be protected from all forms of violence (article 19), including physical and mental abuse and neglect, and from all forms of exploitation, such as hazardous labour (article 32), sexual exploitation (article 34), and exposure to drugs and other harmful substances (article 33).

The CRC pays specific attention to the needs of certain groups of children who need special protection. Children who are victims of neglect, exploitation and abuse (article 36), or torture (article 37), or who are in situations of armed conflict (article 38), are entitled to an environment conducive to their recovery and rehabilitation. The particular needs of refugee children, and children from indigenous or minority groups (article 30), are recognized. Their needs for health and health care must be provided for as well. Article 23 defines the rights of disabled children to be fully active members of their community despite their disability, recognizing that their particular needs relate to their social and psychological development as well as their physical health.

Many other articles of the CRC have a bearing upon a child's health as they relate to the environment in which a child can grow to his or her full potential. Here, the articles that relate to a child's education and leisure, and those that relate to his or her family and the care he or she receives, have an important, though less direct, part to play.

HANDOUT

Session 1.3.3 Adolescents and the Convention on the Rights of the Child (CRC) (General Comment No. 4)

UNITED NATIONS

CRC

Convention on the Rights of the Child

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COMMITTEE ON THE RIGHTS OF THE CHILD
Thirty-third session
19 May-6 June 2003

GENERAL COMMENT NO. 4 (2003)

Adolescent health and development in the context of the Convention on the Rights of the Child

Introduction

1. The Convention on the Rights of the Child defines a child as "every human being below the age of 18 years unless, under the law applicable, majority is attained earlier" (art. 1). Consequently, adolescents up to 18 years old are holders of all the rights enshrined in the Convention; they are entitled to special protection measures and, according to their evolving capacities, they can progressively exercise their rights (art. 5).

2. Adolescence is a period characterized by rapid physical, cognitive and social changes, including sexual and reproductive maturation; the gradual building up of the capacity to assume adult behaviours and roles involving new responsibilities requiring new knowledge and skills. While adolescents are in general a healthy population group, adolescence also poses new challenges to health and development owing to their relative vulnerability and pressure from society, including peers, to adopt risky health behaviour. These challenges include developing an individual identity and dealing with one's sexuality. The dynamic transition period to adulthood is also generally a period of positive changes, prompted by the significant capacity of adolescents to learn rapidly, to experience new and diverse situations, to develop and use critical thinking, to familiarize themselves with freedom, to be creative and to socialize.

3. The Committee on the Rights of the Child notes with concern that in implementing their obligations under the Convention, States parties have not given sufficient attention to the specific concerns of adolescents as rights holders and to promoting their health and development. This has motivated the Committee to adopt the present general comment in order to raise awareness and provide States parties with guidance and support in their efforts to guarantee the respect for, protection and fulfilment of the rights of adolescents, including through the formulation of specific strategies and policies.

4. The Committee understands the concepts of "health and development" more broadly than being strictly limited to the provisions defined in articles 6 (right to life, survival and development) and 24 (right to health) of the Convention. One of the aims of this general comment is precisely to identify the main human rights that need to be promoted and protected in order to ensure that adolescents do enjoy the highest attainable standard of health, develop in a well-balanced manner, and are adequately prepared to enter adulthood and assume a constructive role in their communities and in society at large. This general comment should be read in conjunction with the Convention and its two Optional Protocols on the sale of children, child prostitution and child pornography, and on the involvement of children in armed conflict, as well as other relevant international human rights norms and standards.[1]

I. FUNDAMENTAL PRINCIPLES AND OTHER OBLIGATIONS OF STATES PARTIES

5. As recognized by the World Conference on Human Rights (1993) and repeatedly stated by the Committee, children's rights too are indivisible and interrelated. In addition to articles 6 and 24, other provisions and principles of the Convention are crucial in guaranteeing that adolescents fully enjoy their right to health and development.

The right to non-discrimination

6. States parties have the obligation to ensure that all human beings below 18 enjoy all the rights set forth in the Convention without discrimination (art. 2), including with regard to "race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status". These grounds also cover adolescents' sexual orientation and health status (including HIV/AIDS and mental health). Adolescents who are subject to discrimination are more vulnerable to abuse, other types of violence and exploitation, and their health and development are put at greater risk. They are therefore entitled to special attention and protection from all segments of society.

Appropriate guidance in the exercise of rights

7. The Convention acknowledges the responsibilities, rights and duties of parents (or other persons legally responsible for the child) "to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention" (art. 5). The Committee believes that parents or other persons legally responsible for the child need to fulfil with care their right and responsibility to provide direction and guidance to their adolescent children in the exercise by the latter of their rights. They have an obligation to take into account the adolescents' views, in accordance with their age and maturity, and to provide a safe and supportive environment in which the adolescent can develop. Adolescents need to be recognized by the members of their family environment as

active rights holders who have the capacity to become full and responsible citizens, given the proper guidance and direction.

Respect for the views of the child

8. The right to express views freely and have them duly taken into account (art. 12) is also fundamental in realizing adolescents' right to health and development. States parties need to ensure that adolescents are given a genuine chance to express their views freely on all matters affecting them, especially within the family, in school, and in their communities. In order for adolescents to be able safely and properly to exercise this right, public authorities, parents and other adults working with or for children need to create an environment based on trust, information-sharing, the capacity to listen and sound guidance that is conducive for adolescents' participating equally including in decision-making processes.

Legal and judicial measures and processes

9. Under article 4 of the Convention, "States parties shall undertake all appropriate legislative, administrative and other measures for the implementation of the rights recognized" therein. In the context of the rights of adolescents to health and development, States parties need to ensure that specific legal provisions are guaranteed under domestic law, including with regard to setting a minimum age for sexual consent, marriage and the possibility of medical treatment without parental consent. These minimum ages should be the same for boys and girls (article 2 of the Convention) and closely reflect the recognition of the status of human beings under 18 years of age as rights holders, in accordance with their evolving capacity, age and maturity (arts. 5 and 12 to 17). Further, adolescents need to have easy access to individual complaint systems as well as judicial and appropriate non-judicial redress mechanisms that guarantee fair and due process, with special attention to the right to privacy (art. 16).

Civil rights and freedoms

10. The Convention defines the civil rights and freedoms of children and adolescents in its articles 13 to 17. These are fundamental in guaranteeing the right to health and development of adolescents. Article 17 states that the child has the right to "access information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health". The right of adolescents to access appropriate information is crucial if States parties are to promote cost-effective measures, including through laws, policies and programmes, with regard to numerous health-related situations, including those covered in articles 24 and 33 such as family planning, prevention of accidents, protection from harmful traditional practices, including early marriages and female genital mutilation, and the abuse of alcohol, tobacco and other harmful substances.

11. In order to promote the health and development of adolescents, States parties are also encouraged to respect strictly their right to privacy and confidentiality, including with respect to advice and counselling on health matters (art. 16). Health-care providers have an obligation to keep confidential medical information concerning adolescents, bearing in mind the basic principles of the Convention. Such information may only be disclosed with the consent of the adolescent, or in the same situations applying to the violation of an adult's confidentiality.

Adolescents deemed mature enough to receive counselling without the presence of a parent or other person are entitled to privacy and may request confidential services, including treatment.

Protection from all forms of abuse, neglect, violence and exploitation[2]

12. States parties must take effective measures to ensure that adolescents are protected from all forms of violence, abuse, neglect and exploitation (arts. 19, 32-36 and 38), paying increased attention to the specific forms of abuse, neglect, violence and exploitation that affects this age group. In particular, they should adopt special measures to ensure the physical, sexual and mental integrity of adolescents with disabilities, who are particularly vulnerable to abuse and neglect. States parties should also ensure that adolescents affected by poverty who are socially marginalized are not criminalized. In this regard, financial and human resources need to be allocated to promote research that would inform the adoption of effective local and national laws, policies and programmes. Policies and strategies should be reviewed regularly and revised accordingly. In taking these measures, States parties have to take into account the evolving capacities of adolescents and involve them in an appropriate manner in developing measures, including programmes, designed to protect them. In this context, the Committee emphasizes the positive impact that peer education can have, and the positive influence of proper role models, especially those in the worlds of arts, entertainment and sports.

Data collection

13. Systematic data collection is necessary for States parties to be able to monitor the health and development of adolescents. States parties should adopt data-collection mechanisms that allow desegregation by sex, age, origin and socio-economic status so that the situation of different groups can be followed. Data should also be collected to study the situation of specific groups such as ethnic and/or indigenous minorities, migrant or refugee adolescents, adolescents with disabilities, working adolescents, etc. Where appropriate, adolescents should participate in the analysis to ensure that the information is understood and utilized in an adolescent-sensitive way.

II. CREATING A SAFE AND SUPPORTIVE ENVIRONMENT

14. The health and development of adolescents are strongly determined by the environments in which they live. Creating a safe and supportive environment entails addressing attitudes and actions of both the immediate environment of the adolescent - family, peers, schools and services - as well as the wider environment created by, inter alia, community and religious leaders, the media, national and local policies and legislation. The promotion and enforcement of the provisions and principles of the Convention, especially articles 2-6, 12-17, 24, 28, 29 and 31, are key to guaranteeing adolescents' right to health and development. States parties should take measures to raise awareness and stimulate and/or regulate action through the formulation of policy or the adoption of legislation and the implementation of programmes specifically for adolescents.

15. The Committee stresses the importance of the family environment, including the members of the extended family and community or other persons legally responsible for the child or adolescent (arts. 5 and 18). While most adolescents grow up in well-functioning family environments, for some the family does not constitute a safe and supportive milieu.

16. The Committee calls upon States parties to develop and implement, in a manner consistent with adolescents' evolving capacities, legislation, policies and programmes to promote the health and development of adolescents by (a) providing parents (or legal guardians) with appropriate assistance through the development of institutions, facilities and services that adequately support the well-being of adolescents, including, when needed, the provision of material assistance and support with regard to nutrition, clothing and housing (art. 27 (3)); (b) providing adequate information and parental support to facilitate the development of a relationship of trust and confidence in which issues regarding, for example, sexuality and sexual behaviour and risky lifestyles can be openly discussed and acceptable solutions found that respect the adolescent's rights (art. 27 (3)); (c) providing adolescent mothers and fathers with support and guidance for both their own and their children's well-being (art. 24 (f), 27 (2-3)); (d) giving, while respecting the values and norms of ethnic and other minorities, special attention, guidance and support to adolescents and parents (or legal guardians), whose traditions and norms may differ from those in the society where they live; and (e) ensuring that interventions in the family to protect the adolescent and, when necessary, separate her/him from the family, e.g. in case of abuse or neglect, are in accordance with applicable laws and procedures. Such laws and procedures should be reviewed to ensure that they conform to the principles of the Convention.

17. The school plays an important role in the life of many adolescents, as the venue for learning, development and socialization. Article 29 (1) states that education must be directed to "the development of the child's personality, talents and mental and physical abilities to their fullest potential". In addition, general comment No. 1 on the aims of education states that "Education must also be aimed at ensuring that … no child leaves school without being equipped to face the challenges that he or she can expect to be confronted with in life. Basic skills should include … the ability to make well-balanced decisions; to resolve conflicts in a non-violent manner; and to develop a healthy lifestyle [and] good social relationships …". Considering the importance of appropriate education for the current and future health and development of adolescents, as well as for their children, the Committee urges States parties, in line with articles 28 and 29 of the Convention to (a) ensure that quality primary education is compulsory and available, accessible and free to all and that secondary and higher education are available and accessible to all adolescents; (b) provide well-functioning school and recreational facilities which do not pose health risks to students, including water and sanitation and safe journeys to school; (c) take the necessary actions to prevent and prohibit all forms of violence and abuse, including sexual abuse, corporal punishment and other inhuman, degrading or humiliating treatment or punishment in school, by school personnel as well as among students; (d) initiate and support measures, attitudes and activities that promote healthy behaviour by including relevant topics in school curricula.

18. During adolescence, an increasing number of young people are leaving school to start working to help support their families or for wages in the formal or informal sector. Participation in work activities in accordance with international standards, as long as it does not jeopardize the enjoyment of any of the other rights of adolescents, including health and education, may be beneficial for the development of the adolescent. The Committee urges States parties to take all necessary measures to abolish all forms of child labour, starting with the worst forms, to continuously review national regulations on minimum ages for employment with a view to making them compatible with international standards, and to regulate the working environment and conditions for adolescents who are working (in accordance with article 32 of the

Convention, as well as ILO Conventions Nos. 138 and 182), so as to ensure that they are fully protected and have access to legal redress mechanisms.

19. The Committee also stresses that in accordance with article 23 (3) of the Convention, the special rights of adolescents with disabilities should be taken into account and assistance provided to ensure that the disabled child/adolescent has effective access to and receives good quality education. States should recognize the principle of equal primary, secondary and tertiary educational opportunities for disabled children/adolescents, where possible in regular schools.

20. The Committee is concerned that early marriage and pregnancy are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS. Both the legal minimum age and actual age of marriage, particularly for girls, are still very low in several States parties. There are also non-health-related concerns: children who marry, especially girls, are often obliged to leave the education system and are marginalized from social activities. Further, in some States parties married children are legally considered adults, even if they are under 18, depriving them of all the special protection measures they are entitled under the Convention. The Committee strongly recommends that States parties review and, where necessary, reform their legislation and practice to increase the minimum age for marriage with and without parental consent to 18 years, for both girls and boys. The Committee on the Elimination of Discrimination against Women has made a similar recommendation (general comment No. 21 of 1994).

21. In most countries accidental injuries or injuries due to violence are a leading cause of death or permanent disability among adolescents. In that respect, the Committee is concerned about the injuries and death resulting from road traffic accidents, which affect adolescents disproportionately. States parties should adopt and enforce legislation and programmes to improve road safety, including driving education for and examination of adolescents and the adoption or strengthening of legislation known to be highly effective such as the obligations to have a valid driver's licence, wear seat belts and crash helmets, and the designation of pedestrian areas.

22. The Committee is also very concerned about the high rate of suicide among this age group. Mental disorders and psychosocial illness are relatively common among adolescents. In many countries symptoms such as depression, eating disorders and self-destructive behaviours, sometimes leading to self-inflicted injuries and suicide, are increasing. They may be related to, inter alia, violence, ill-treatment, abuse and neglect, including sexual abuse, unrealistically high expectations, and/or bullying or hazing in and outside school. States parties should provide these adolescents with all the necessary services.

23. Violence results from a complex interplay of individual, family, community and societal factors. Vulnerable adolescents such as those who are homeless or who are living in institutions, who belong to gangs or who have been recruited as child soldiers are especially exposed to both institutional and interpersonal violence. Under article 19 of the Convention, States parties must take all appropriate measures[3] to prevent and eliminate: (a) institutional violence against adolescents, including through legislation and administrative measures in relation to public and private institutions for adolescents (schools, institutions for disabled adolescents, juvenile reformatories, etc.), and training and monitoring of personnel in charge of institutionalized children or who otherwise have contact with children through their work, including the police; and (b) interpersonal violence among adolescents, including by supporting adequate parenting

and opportunities for social and educational development in early childhood, fostering non-violent cultural norms and values (as foreseen in article 29 of the Convention), strictly controlling firearms and restricting access to alcohol and drugs.

24. In light of articles 3, 6, 12, 19 and 24 (3) of the Convention, States parties should take all effective measures to eliminate all acts and activities which threaten the right to life of adolescents, including honour killings. The Committee strongly urges States parties to develop and implement awareness-raising campaigns, education programmes and legislation aimed at changing prevailing attitudes, and address gender roles and stereotypes that contribute to harmful traditional practices. Further, States parties should facilitate the establishment of multidisciplinary information and advice centres regarding the harmful aspects of some traditional practices, including early marriage and female genital mutilation.

25. The Committee is concerned about the influence exerted on adolescent health behaviours by the marketing of unhealthy products and lifestyles. In line with article 17 of the Convention, States parties are urged to protect adolescents from information that is harmful to their health and development, while underscoring their right to information and material from diverse national and international sources. States parties are therefore urged to regulate or prohibit information on and marketing of substances such as alcohol and tobacco, particularly when it targets children and adolescents[4].

III. INFORMATION, SKILLS DEVELOPMENT, COUNSELLING, AND HEALTH SERVICES

26. Adolescents have the right to access adequate information essential for their health and development and for their ability to participate meaningfully in society. It is the obligation of States parties to ensure that all adolescent girls and boys, both in and out of school, are provided with, and not denied, accurate and appropriate information on how to protect their health and development and practise healthy behaviours. This should include information on the use and abuse, of tobacco, alcohol and other substances, safe and respectful social and sexual behaviours, diet and physical activity.

27. In order to act adequately on the information, adolescents need to develop the skills necessary, including self-care skills, such as how to plan and prepare nutritionally balanced meals and proper personal hygiene habits, and skills for dealing with particular social situations such as interpersonal communication, decision-making, and coping with stress and conflict. States parties should stimulate and support opportunities to build such skills through, inter alia, formal and informal education and training programmes, youth organizations and the media.

28. In light of articles 3, 17 and 24 of the Convention, States parties should provide adolescents with access to sexual and reproductive information, including on family planning and contraceptives, the dangers of early pregnancy, the prevention of HIV/AIDS and the prevention and treatment of sexually transmitted diseases (STDs). In addition, States parties should ensure that they have access to appropriate information, regardless of their marital status and whether their parents or guardians consent. It is essential to find proper means and methods of providing information that is adequate and sensitive to the particularities and specific rights of adolescent girls and boys. To this end, States parties are encouraged to ensure that adolescents are actively involved in the design and dissemination of information through a variety of

channels beyond the school, including youth organizations, religious, community and other groups and the media.

29. Under article 24 of the Convention, States parties are urged to provide adequate treatment and rehabilitation for adolescents with mental disorders, to make the community aware of the early signs and symptoms and the seriousness of these conditions, and to protect adolescents from undue pressures, including psychosocial stress. States parties are also urged to combat discrimination and stigma surrounding mental disorders, in line with their obligations under article 2. Every adolescent with a mental disorder has the right to be treated and cared for, as far as possible, in the community in which he or she lives. Where hospitalization or placement in a psychiatric institution is necessary, this decision should be made in accordance with the principle of the best interests of the child. In the event of hospitalization or institutionalization, the patient should be given the maximum possible opportunity to enjoy all his or her rights as recognized under the Convention, including the rights to education and to have access to recreational activities.[5] Where appropriate, adolescents should be separated from adults. States parties must ensure that adolescents have access to a personal representative other than a family member to represent their interests, when necessary and appropriate.[6] In accordance with article 25 of the Convention, States parties should undertake periodic review of the placement of adolescents in hospitals or psychiatric institutions.

30. Adolescents, both girls and boys, are at risk of being infected with and affected by STDs, including HIV/AIDS[7]. States should ensure that appropriate goods, services and information for the prevention and treatment of STDs, including HIV/AIDS, are available and accessible. To this end, States parties are urged (a) to develop effective prevention programmes, including measures aimed at changing cultural views about adolescents' need for contraception and STD prevention and addressing cultural and other taboos surrounding adolescent sexuality; (b) to adopt legislation to combat practices that either increase adolescents' risk of infection or contribute to the marginalization of adolescents who are already infected with STDs, including HIV; (c) to take measures to remove all barriers hindering the access of adolescents to information, preventive measures such as condoms, and care.

31. Adolescent girls should have access to information on the harm that early marriage and early pregnancy can cause, and those who become pregnant should have access to health services that are sensitive to their rights and particular needs. States parties should take measures to reduce maternal morbidity and mortality in adolescent girls, particularly caused by early pregnancy and unsafe abortion practices, and to support adolescent parents. Young mothers, especially where support is lacking, may be prone to depression and anxiety, compromising their ability to care for their child. The Committee urges States parties (a) to develop and implement programmes that provide access to sexual and reproductive health services, including family planning, contraception and safe abortion services where abortion is not against the law, adequate and comprehensive obstetric care and counselling; (b) to foster positive and supportive attitudes towards adolescent parenthood for their mothers and fathers; and (c) to develop policies that will allow adolescent mothers to continue their education.

32. Before parents give their consent, adolescents need to have a chance to express their views freely and their views should be given due weight, in accordance with article 12 of the Convention. However, if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the "best interest of the child" (art. 3).

33. With regard to privacy and confidentiality, and the related issue of informed consent to treatment, States parties should (a) enact laws or regulations to ensure that confidential advice concerning treatment is provided to adolescents so that they can give their informed consent. Such laws or regulations should stipulate an age for this process, or refer to the evolving capacity of the child; and (b) provide training for health personnel on the rights of adolescents to privacy and confidentiality, to be informed about planned treatment and to give their informed consent to treatment.

IV. VULNERABILITY AND RISK

34. In ensuring respect for the right of adolescents to health and development, both individual behaviours and environmental factors which increase their vulnerability and risk should be taken into consideration. Environmental factors, such as armed conflict or social exclusion, increase the vulnerability of adolescents to abuse, other forms of violence and exploitation, thereby severely limiting adolescents' abilities to make individual, healthy behaviour choices. For example, the decision to engage in unsafe sex increases adolescents' risk of ill-health.

35. In accordance with article 23 of the Convention, adolescents with mental and/or physical disabilities have an equal right to the highest attainable standard of physical and mental health. States parties have an obligation to provide adolescents with disabilities with the means necessary to realize their rights.[8] States parties should (a) ensure that health facilities, goods and services are available and accessible to all adolescents with disabilities and that these facilities and services promote their self-reliance and their active participation in the community; (b) ensure that the necessary equipment and personal support are available to enable them to move around, participate and communicate; (c) pay specific attention to the special needs relating to the sexuality of adolescents with disabilities; and (d) remove barriers that hinder adolescents with disabilities in realizing their rights.

36. States parties have to provide special protection to homeless adolescents, including those working in the informal sector. Homeless adolescents are particularly vulnerable to violence, abuse and sexual exploitation from others, self-destructive behaviour, substance abuse and mental disorders. In this regard, States parties are required to (a) develop policies and enact and enforce legislation that protect such adolescents from violence, e.g. by law enforcement officials; (b) develop strategies for the provision of appropriate education and access to health care, and of opportunities for the development of livelihood skills.

37. Adolescents who are sexually exploited, including in prostitution and pornography, are exposed to significant health risks, including STDs, HIV/AIDS, unwanted pregnancies, unsafe abortions, violence and psychological distress. They have the right to physical and psychological recovery and social reintegration in an environment that fosters health, self-respect and dignity (art. 39). It is the obligation of States parties to enact and enforce laws to prohibit all forms of sexual exploitation and related trafficking; to collaborate with other States parties to eliminate intercountry trafficking; and to provide appropriate health and counselling services to adolescents who have been sexually exploited, making sure that they are treated as victims and not as offenders.

38. Additionally, adolescents experiencing poverty, armed conflicts, all forms of injustice, family breakdown, political, social and economic instability and all types of migration may be

particularly vulnerable. These situations might seriously hamper their health and development. By investing heavily in preventive policies and measures States parties can drastically reduce levels of vulnerability and risk factors; they will also provide cost-effective ways for society to help adolescents develop harmoniously in a free society.

V. NATURE OF STATES' OBLIGATIONS

39. In exercising their obligations in relation to the health and development of adolescents, States parties shall always take fully into account the four general principles of the Convention. It is the view of the Committee that States parties must take all appropriate legislative, administrative and other measures for the realization and monitoring of the rights of adolescents to health and development as recognized in the Convention. To this end, States parties must notably fulfil the following obligations:

(a) To create a safe and supportive environment for adolescents, including within their family, in schools, in all types of institutions in which they may live, within their workplace and/or in the society at large;

(b) To ensure that adolescents have access to the information that is essential for their health and development and that they have opportunities to participate in decisions affecting their health (notably through informed consent and the right of confidentiality), to acquire life skills, to obtain adequate and age-appropriate information, and to make appropriate health behaviour choices;

(c) To ensure that health facilities, goods and services, including counselling and health services for mental and sexual and reproductive health, of appropriate quality and sensitive to adolescents' concerns are available to all adolescents;

(d) To ensure that adolescent girls and boys have the opportunity to participate actively in planning and programming for their own health and development;

(e) To protect adolescents from all forms of labour which may jeopardize the enjoyment of their rights, notably by abolishing all forms of child labour and by regulating the working environment and conditions in accordance with international standards;

(f) To protect adolescents from all forms of intentional and unintentional injuries, including those resulting from violence and road traffic accidents;

(g) To protect adolescents from all harmful traditional practices, such as early marriages, honour killings and female genital mutilation;

(h) To ensure that adolescents belonging to especially vulnerable groups are fully taken into account in the fulfilment of all aforementioned obligations;

(i) To implement measures for the prevention of mental disorders and the promotion of mental health of adolescents.

40. The Committee draws the attention of States parties to the general comment No. 14 on the right to the highest attainable standard of health of the Committee on Economic, Social and Cultural Rights which states that, "States parties should provide a safe and supportive

environment for adolescents that ensures the opportunity to participate in decisions affecting their health, to build life skills, to acquire appropriate information, to receive counselling and to negotiate the health-behaviour choices they make. The realization of the right to health of adolescents is dependent on the development of youth-sensitive health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services."

41. In accordance with articles 24, 39 and other related provisions of the Convention, States parties should provide health services that are sensitive to the particular needs and human rights of all adolescents, paying attention to the following characteristics:

(a) *Availability*. Primary health care should include services sensitive to the needs of adolescents, with special attention given to sexual and reproductive health and mental health;

(b) *Accessibility.* Health facilities, goods and services should be known and easily accessible (economically, physically and socially) to all adolescents, without discrimination. Confidentiality should be guaranteed, when necessary;

(c) *Acceptability.* While fully respecting the provisions and principles of the Convention, all health facilities, goods and services should respect cultural values, be gender sensitive, be respectful of medical ethics and be acceptable to both adolescents and the communities in which they live;

(d) *Quality.* Health services and goods should be scientifically and medically appropriate, which requires personnel trained to care for adolescents, adequate facilities and scientifically accepted methods.

42. States parties should, where feasible, adopt a multisectoral approach to the promotion and protection of adolescent health and development by facilitating effective and sustainable linkages and partnerships among all relevant actors. At the national level, such an approach calls for close and systematic collaboration and coordination within Government, so as to ensure the necessary involvement of all relevant government entities. Public health and other services utilized by adolescents should also be encouraged and assisted in seeking collaboration with, inter alia, private and/or traditional practitioners, professional associations, pharmacies and organizations that provide services to vulnerable groups of adolescents.

43. A multisectoral approach to the promotion and protection of adolescent health and development will not be effective without international cooperation. Therefore, States parties should, when appropriate, seek such cooperation with United Nations specialized agencies, programmes and bodies, international NGOs and bilateral aid agencies, international professional associations and other non-State actors.

Notes

[1] These include the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the International Convention on the Elimination of All Forms of Racial Discrimination, the International Convention on the

Protection of the Rights of All Migrant Workers and Members of Their Families and the Convention on the Elimination of All Forms of Discrimination Against Women.

[2] See also the reports of the Committee's days of general discussion on "Violence against children" held in 2000 and 2001 and the Recommendations adopted in this regard (see CRC/C/100, chap. V and CRC/C/111, chap. V).

[3] Ibid.

[4] As proposed in the Framework Convention on Tobacco Control (2003) of the World Health Organization.

[5] For further guidance on this subject, refer to the Principles for the Protection of Persons with Mental Illness and for the Improvement of Mental Health Care, (General Assembly resolution 46/119 of 17 December 1991, annex).

[6] Ibid., in particular principles 2, 3 and 7.

[7] For further guidance on this issue, see general comment No. 3 (2003) on HIV/AIDS and the rights of children.

[8] United Nations Standard Rules on Equal Opportunities for Persons with Disabilities.

Session 1.3.3 The relevance of human rights to adolescent health and development

UN Convention on the Rights of the Child case studies

Case study 1: Rowena

Rowena is 14 years old. She is leaning against a wall outside the clinic looking downcast. She has just come out of the clinic but she has not been able to see a health worker. The clinic staff told her to go away. Rowena used to live in the deep countryside and she never went to school and she cannot read. When the crops failed again, she decided that she would move away from her family to the city. She had heard that, by working as a sex worker in the town, she could earn a lot of money that she could send home to her family. Now she has picked up an infection so she has gone to the clinic for help. The staff at the clinic asked her for her registration papers but she did not have any, and she did not know how to write to fill in the forms, so they said she could not be treated there. One of the clinic workers told her that she should not be surprised to have an infection if she did that sort of work.

What rights and obligations are involved in this story?

List the rights involved:

Which rights are not being met?

HANDOUT

Session 1.3.3 The relevance of human rights to adolescent health and development

UN Convention on the Rights of the Child (CRC) case studies

Case study 2: Alia

Alia is 12 years old. She is going to school and is doing well. She would like to continue her studies, but her parents have just told her that she is to be married. She is frightened at the prospect because a friend of her sister recently had a baby when she was 14 years old and she bled badly and nearly died. She feels she cannot talk to anyone about her worries. Her sister says that the nurse at the health centre is very kind and understanding, but the clinic is not open when Alia gets out of school, and anyway she knows that her mother would not let her speak to the nurse on her own.

What rights and obligations are involved in this story?

List the rights involved:

Which rights are not being met?

Session 1.3.4 Instructions for group work (buzz groups)

- Each buzz group will be assigned one health issue from the flipchart. The buzz group should identify one group of adolescents who are at *high risk*, one group at *intermediate risk* and one group at *low risk* for their assigned health issue.
- In addition, discuss to what extent (or degree) each of the groups (high, intermediate and low risk) has *access to health information and services* to prevent or treat the health issue.
- You have 5 minutes to complete the exercise.

Notes

DAY 2:

Programming for adolescent health and development using the MAPM framework

Detailed agenda for day 2

Time	Minutes	Sessions and activities (minutes)	Materials
08:30	20	Administrative issues, flashback and agenda for day 2	**Flipchart** Flipchart 16 *Day 2 flashback* **VIPP cards** One VIPP card for each participant
08:50	70	**2.1 Introduction to the Mapping Adolescent Programming and Measurement (MAPM) framework** 2.1.1 Introduction (5) 2.1.2 Interactive presentation of MAPM (45) 2.1.3 Discussion (20)	**Presentation** 2.1.2 *Introduction to the MAPM framework* **Handout** 2.1 *Mapping adolescent programming and measurement*
10:00	30	Break	
10:30	90	**2.2 Using the MAPM framework to design or review programmes** 2.2.1 Introduction to group work (10) 2.2.2 Group work (40) 2.2.3 Report back and wrap up (40)	**Handouts** 2.2.1 *MAPM memory aid for participants* *Instructions for group work: session 2.2.2* **VIPP cards** Three VIPP cards to use as headings 20 VIPP cards (or more) (white, pink, blue)
12:00	60	**2.3 A closer look at determinants** 2.3.1 Introduction (5) 2.3.2 Presentation on determinants (40) 2.3.3 Introduction to group work (15)	**Presentation** 2.3.2 *Determinants* **Handouts** 2.3 *Risk and protective factors that are feasible to change by programmes* *Instructions for group work: session 2.3.4*
13:00	60	Lunch	
14:00	90	2.3.4 Group work (40) 2.3.5 Report back and wrap up (30)  Participants' presentation time (optional) (20)	**Handout** *Questions at report back: session 2.3.5* **VIPP cards** Pink VIPP cards
15:30	30	Break	
16:00	90	**2.4 Planning for HIV and reproductive health programmes I** 2.4.1 Introduction to group work (15) 2.4.2 Group work (45) 2.4.3 Report back (30)	**Handout** *Instructions for group work: session 2.4.2*
17:30	15	**2.5 Day 2 wrap-up**	**Flipchart** Flipchart 15 *Personal diary questions*

Administrative issues, flashback and agenda for Day 2

20 MIN

Materials

- Flipchart 16 *Day 2 flashback*
- One VIPP card for each participant

Steps

a. Administrative issues

- Make necessary announcements related to administration and logistics (e.g. meals, transportation, lodging, fees or per diems, or any other matter that was identified by the course facilitators or participants).
- Ask the participants if they have any questions. If you cannot answer quickly, schedule a time for further discussion (e.g. break, end of day), or tell the participant whom they should contact for a response.

b. Flashback

(**Note to facilitator:** the first feedback session sets the tone for feedback on other days. Daily feedback should avoid having participants recount all sessions and should focus rather on experiences, opinions, positive and negative comments on sessions, and identifying gaps. They can also comment on the course methodology and environment: participatory or non-participatory, food, coffee, room, the equipment and the hotel).

- Give each participant one VIPP card and distribute marker pens.
- Show Flipchart 16:

FLIPCHART 16 Day 2 flashback

Think about yesterday and write on your card:

One new thing that you learnt or understood better about young people (a fact, a feeling, etc.)

- Remind participants what the VIPP rules are.
- Tell participants that they have 30 seconds to write on their cards.
- Tell them that when they are finished writing to put their cards face down on a chair in the centre of the room. Gather the cards.
- Ask two volunteers to hold up and read out the cards one at a time.
- Stick the VIPP cards on the flipchart, clustering similar cards.
- Review the responses and thank the participants.

c. Agenda

- Go through the agenda for day 2 using the handout *Five-day agenda.*
- If there are any changes from the written agenda, explain them.

Session 2.1 Introduction to the Mapping Adolescent Programming and Measurement (MAPM) framework

Agenda for introduction to the MAPM framework	
00:05	2.1.1 Introduction
00:45	2.1.2 Interactive presentation of MAPM
00:20	2.1.3 Discussion
01:10	

Note to facilitator

During this session:

- Encourage questions and comments
- Do not feel obliged to respond to all questions yourself. If appropriate, invite other participants to respond. This will help the participants to relax and feel comfortable about sharing what they know.

Session objectives

By the end of this session participants will be able to:

- Recognize the MAPM framework;
- Define the elements of the MAPM framework: health outcomes, behaviours, determinants and interventions;
- Describe how the MAPM framework links these elements together in a logical manner;
- Explain how the MAPM framework can be used to design or review programmes.

Preparation

Presentation

2.1.2 *Introduction to the MAPM framework*

2.1.1 Introduction

5 MIN

Materials

Handout: *Five-day agenda*

Steps

a. Introduce the session objectives using the handout.

b. Explain the activities planned for the session and the time allocated for each activity.

c. Ask the participants if they have any questions.

2.1.2 Interactive presentation of MAPM

45 MIN

Materials

- Presentation: 2.1.2 *Introduction to the MAPM framework*
- Handout: *Mapping adolescent programming and measurement*

Steps

a. Go through presentation *Introduction to the MAPM framework* and the talking points.

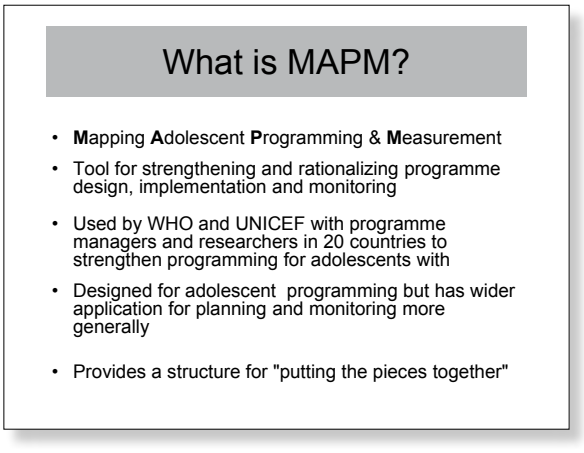
b. Stop where indicated to ask checking questions.

c. Give further explanations and examples in order to overcome any misunderstandings.

Talking points

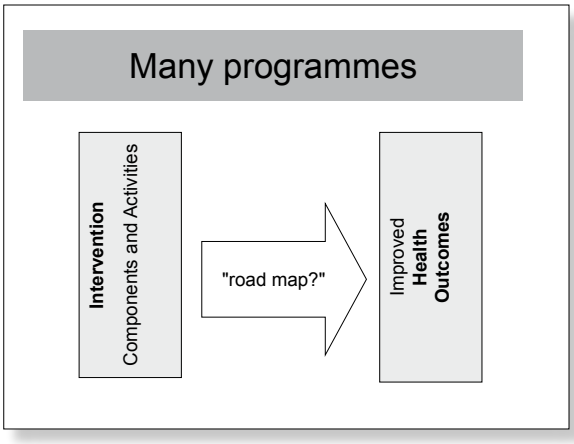
Slide 1 What is MAPM?

The Mapping Adolescent Programming and Measurement framework is a tool for designing, implementing, monitoring and evaluating evidence-informed programmes for adolescent health and development.



Slide 2 Many programmes

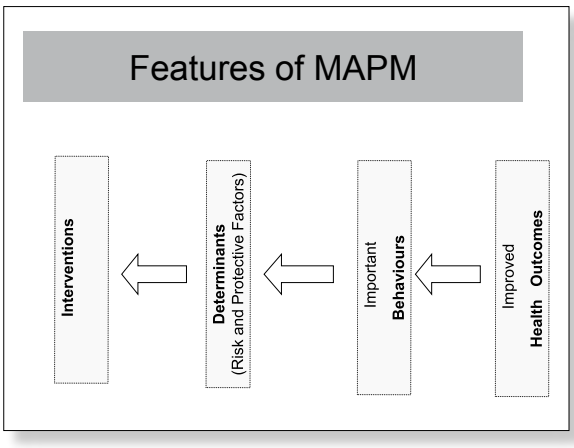
The MAPM tool provides a structure for thinking which guides programme managers, like a "road map", on how interventions can lead to desired outcomes – in this case health and development outcomes for young people.



Slide 3 Features of MAPM

We build the framework from right to left.

Health and development outcomes. These are the results a programme wants to achieve in the long term. Outcomes can be health-specific, such as improving adolescent sexual health or reducing HIV prevalence, or they can focus on developmental aspects of adolescents' lives, such as increasing girls' education.



Behaviours. These are actions that are related to the health and development outcomes that have been selected by a programme as the results that they want to achieve. Behaviours are considered *positive* if they improve a health goal, and *negative* if they act to prevent a health goal.

Determinants. These are the factors that influence behaviour. They include characteristics of individual adolescents, as well as characteristics of their peers, families, schools and health services. They can be *negative* determinants, also called *risk factors*, which *reduce* the likelihood of engaging in behaviours that lead to healthy outcomes; or they can be *positive* determinants, called *protective factors*, which *increase* the chances of engaging in behaviours that produce or lead to healthy outcomes.

Interventions. These are activities designed to change the determinants (the risk and protective factors), thereby changing selected behaviours and the desired health or development outcome. Depending on the determinant to be addressed, interventions can be directed at adolescents, adults or institutions.

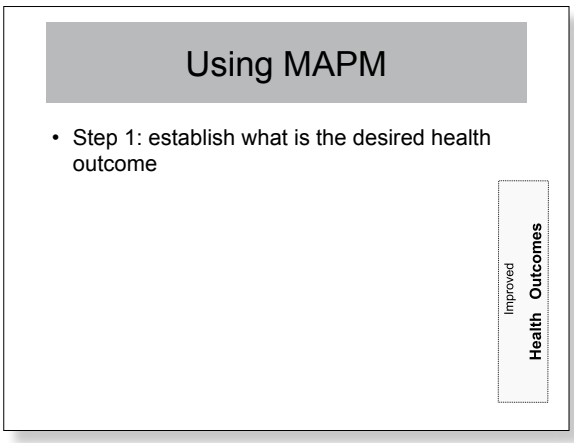
Slide 4 Using MAPM: step 1

Step 1: establish what is the desired health or development outcome.

One example of a desired health outcome is "low rates of unwanted pregnancies among teenage girls".

Question

- What are some other examples of desired health or development outcomes among young people?



Slide 5 Using MAPM: step 2

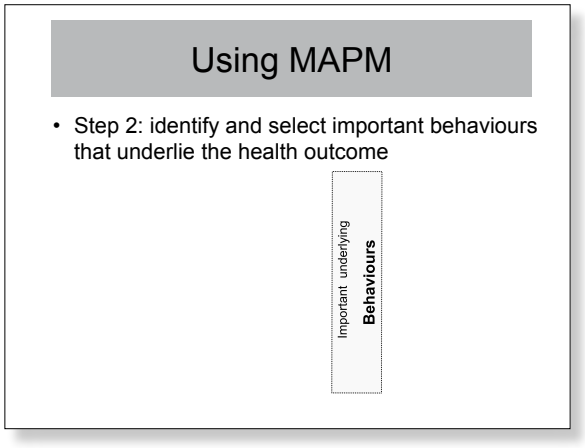
Step 2: identify and select important behaviours that underlie the health or development outcome.

One example of behaviour that contributes to lower rates of unwanted teenage pregnancies is "delayed initiation of sexual activity after the age of 16".

Question

- What other behaviours (or actions) could contribute to lower rates of unwanted pregnancies among teenage girls?

The best way to identify these important behaviours is to review the results of behavioural research.



Slide 6 Using MAPM: step 3

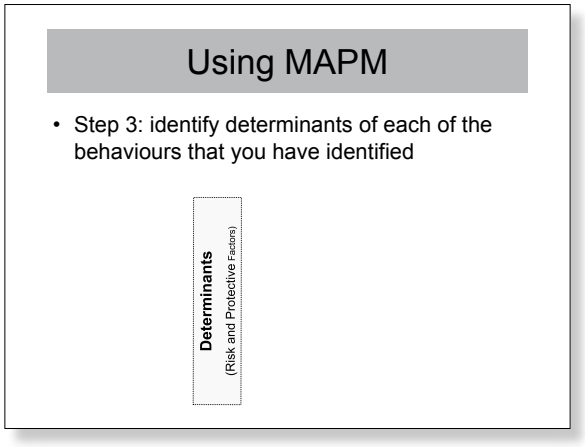
Step 3: identify determinants of each of the behaviours that you have identified.

Determinants are factors that affect behaviour (change). It is important to know that no one factor alone can change a behaviour.

"Parental or societal values against premarital sex" is an example of one determinant for delayed initiation of sexual activity among teenage girls.

Question

- What is another factor that might influence delayed initiation of sexual activity among teenage girls?

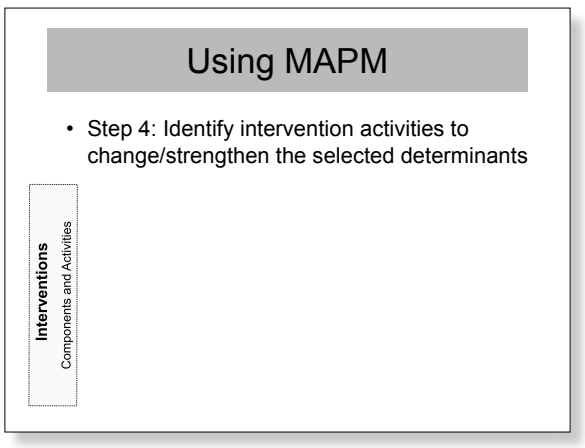


Slide 7 Using MAPM: step 4

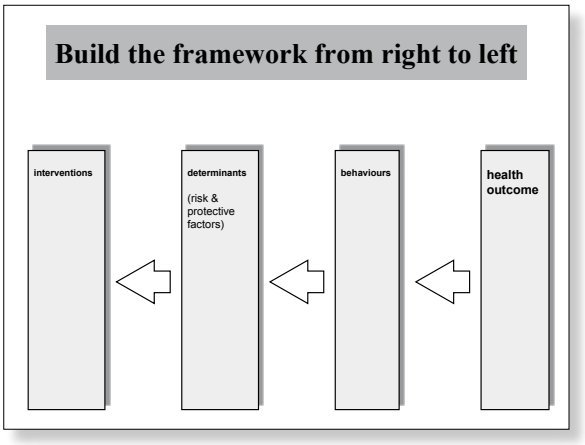
Step 4: Identify intervention activities to change or strengthen the selected determinants.

"Parenting programmes to improve communication on values about premarital sex" is an example of an intervention activity to improve parental communication with adolescents so that they are clear about "parental or societal values against premarital sex" (i.e. the determinant listed above).

There is a growing evidence base on interventions that affect selected determinants. Without this evidence base, it is not feasible to achieve desired health outcomes through behaviour change.



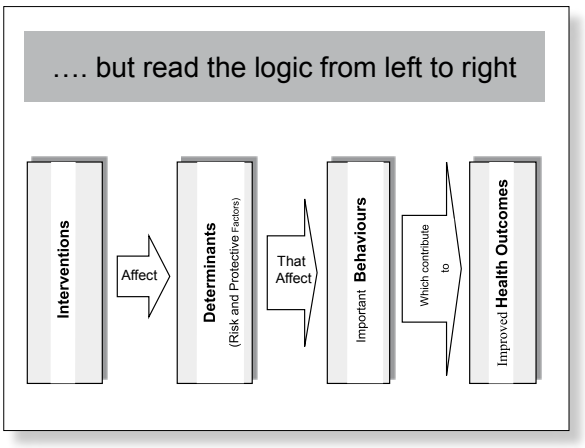
Slide 8 Build the framework from right to left…



Slide 9 …but read the logic from left to right

These four steps define the pathway through which intervention activities can ultimately produce changes in health or development outcomes.

They also provide options for showing results at each step of the way: intervention; determinants; behaviours; outcome. We do not have to wait for the health or development outcome to be achieved before we can start to show results.



Introduction for next slide: How do we know our logic is valid?

- Building a MAPM framework is relatively easy. However, being assured that it stands up to scrutiny and is valid in practice depends on whether the information is based as much as possible on evidence.
- Question: What kind of evidence would we be looking for?
- Causal relationships between the boxes, or at least a strong association. Information from other settings (similar or dissimilar) increases our confidence.
- Implication: involve researchers or use a cyclical approach by developing the framework, checking for evidence, questioning and refining the framework.

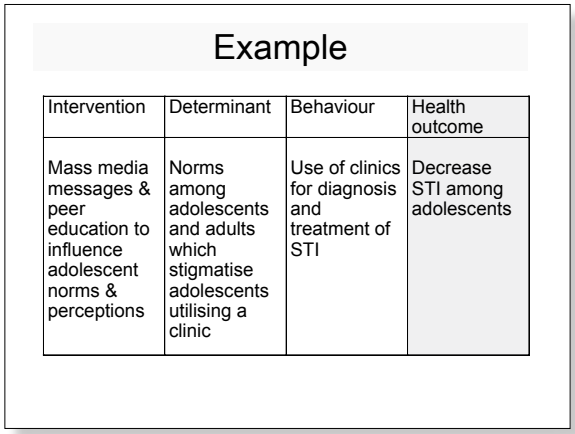
Slide 10 Example of decreasing sexually transmitted infections (STIs)

Question

- Could someone explain this slide based on what I have said so far?

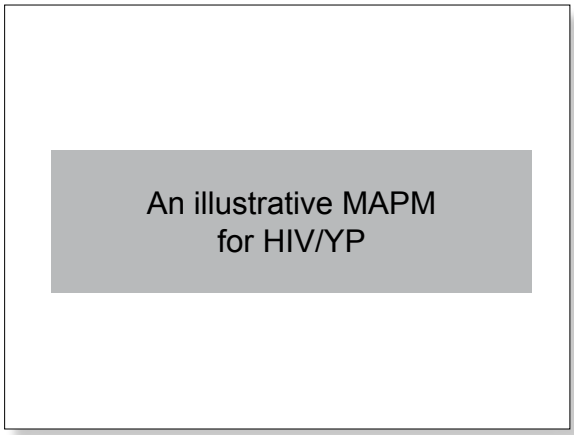
Thank the participant and ask, "Do we all agree with this interpretation? If not, what would you say differently?"

Try to overcome any misunderstandings.



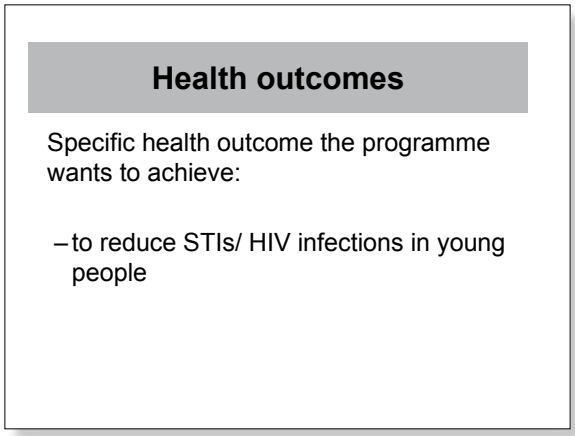
Slide 11 An illustrative MAPM for HIV and young people

Here is another example.



Slide 12 Health outcomes

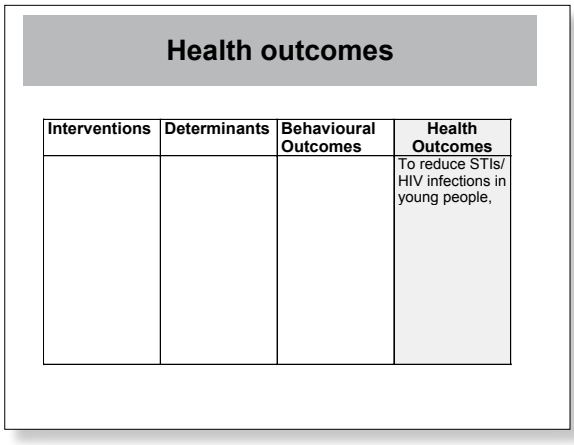
We begin with our desired health outcome.



Slide 13 Health outcomes

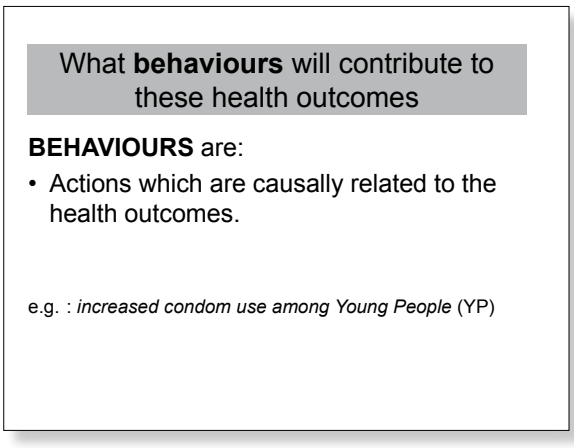
Note the specificity of reducing HIV among *young people.*

These health outcomes could be goals at the national level, at state or district level, or for your organization.



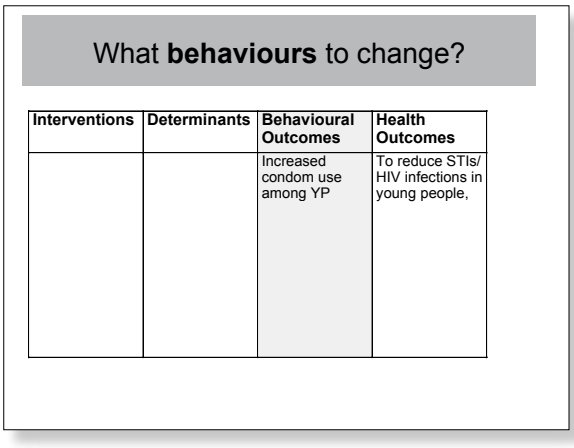
Slide 14 What behaviours will contribute to these health outcomes?

Develop a list of behaviours that *directly* affect the health outcome.



Slide 15 What behaviours to change?

Increased condom use protects against sexually transmitted infections, including HIV.



Slide 16 What determinants will affect this behaviour and can themselves be changed?

These factors:

- are shown by research to be associated with and causal to the selected behaviour;
- can be changed through an intervention.

What **determinants** will affect this behaviour & can itself be changed?

DETERMINANTS are:

- risk and protective factors that affect behaviors

e.g. *Young People's beliefs/norms about condoms*
e.g. Knowledge and skills of health care providers
e.g. Clinic standards & policy on YFHS

Slide 17 What determinants will affect this behaviour and can be changed?

Categories of determinants:

- beliefs and norms of young people
- knowledge, skills and attitudes – such as demonstrating respect towards young people – of health practitioners or other adults
- institutional standards and policies, such as the policy of confidentiality in a clinic.

What determinants will affect this behaviour & can be changed?

Interventions	Determinants	Behavioural Outcomes	Health Outcomes
	YP's beliefs/norms about condoms Knowledge and skills Of health providers Clinic standards & policy on YFHS	Increased condom use among YP	To reduce STIs/ HIV infections in young people,

Slide 18 What interventions are important to implement?

Qualities of a good intervention:

- many channels
- same message
- consistency
- high intensity.

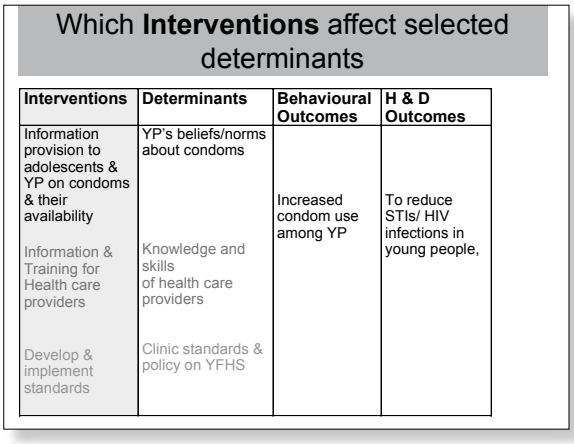
What **interventions are** important to implement?

INTERVENTIONS are:

- Programmatic activities designed to change behaviours; but in fact they must first change determinants, in order to affect behaviours and, ultimately the desired health outcomes.

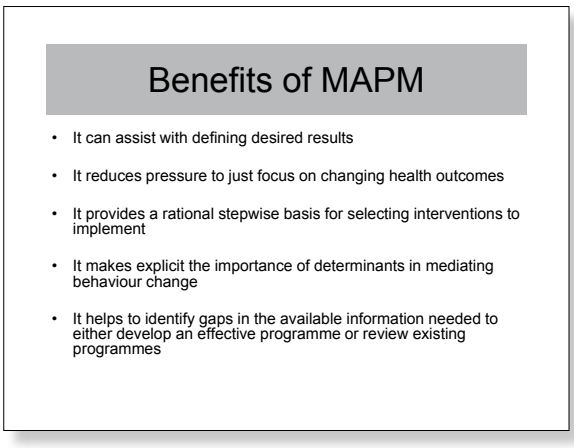
e.g. - *Information provision for YP*
e.g. - Information & Training for Health care providers
e.g. - Develop & implement standards

Slide 19 Which interventions affect selected determinants?



Slide 20 Benefits of MAPM

(Read out the slide.)



2.1.3 Discussion

Steps

a. Ask if there are any questions.

b. Review any of the slides that participants need to be clarified.

c. If appropriate, encourage other participants to respond to questions.

d. Try to overcome any important difficulties, misunderstandings or negative attitudes.

e. If there is enough time, ask:

- Has anyone used this framework, or a framework similar to this one, to develop programmes or interventions?
- If yes, ask one person to briefly explain his or her experience. What was the desired health outcome? How long did the process take, from identifying health outcomes to defining interventions? Who was involved?

f. If nobody has an experience to share, and there is enough time, ask,"In two sentences, how would you describe this MAPM framework to a colleague who did not participate in this training course?"

g. Review the session objectives with participants.

Session 2.2 Using the MAPM framework to design or review programmes

Agenda for using the MAPM framework to design or review programmes	
00:10	2.2.1 Introduction to group work
00:40	2.2.2 Group work
00:40	2.2.3 Report back and wrap up
01:30	

Note to facilitator

The groups will need support during this session. Refer to the MAPM manual to respond to questions and issues that arise during the MAPM session.

It is normal for there to be some discussion and lack of clarity when deciding what column an issue belongs. Do not try to answer for the group, but assist them to learn how to:

- assign issues to appropriate columns: highlight differences between determinants and behavioural outcomes;
- be consistent with use of language: improved determinants will lead to improved health outcomes;
- avoid developing a framework using one participant's current work or project, etc. This tends to make people defensive and singles out one participant who may impose a view.

Session objectives

By the end of this session participants will be able to:

- apply the MAPM framework to address a specific health or development outcome;
- recognize similarities and differences – in terms of behaviours, determinants and interventions – between health outcomes (e.g. the prevention of HIV among young people, and the prevention of too early or unwanted pregnancy);
- understand how the MAPM process helps define some specifics in behaviours, determinants and interventions that should be implemented or tracked.

Preparation

Handouts

- 2.2.1 *MAPM memory aid for participants*
- *Instructions for group work: session 2.2.2*

Other

- Three VIPP cards to use as headings
- 20 VIPP cards (or more) (white, pink, blue)

Note to facilitator

- Based on the profile of the participants, decide which participants will work in group 1, focusing on the prevention of HIV in young people, and which participants will work in group 2, focusing on too early or unwanted pregnancy among adolescents.
- Groups of 7–8 participants are optimal. If the groups need to be bigger, it is better to form a third or fourth group (groups 3 and 4). They can be assigned the same task as groups 1 and 2, respectively. There are 40 minutes assigned for reporting back and wrapping up, so divide the time among the groups.
- Decide which facilitator(s) will work with group 1, and which facilitator(s) will work with group 2 (3 and 4).
- Gather additional materials:
  - 20 VIPP cards (or more if there are groups 3 and 4) of each of the following colours: white, pink, blue (i.e. 10 cards of each colour for each group)
  - Three prepared VIPP cards to use as headings.
- On a white card write “interventions”, on a pink card write “determinants”, and on a blue card write “behaviours”. Pin these up where all the groups can see them (a second set in another room if necessary). If participants use the wrong colour the feedback is confusing.

Breaks

The morning break can be before dividing into groups, but ensure participants get back from the break and begin the group work. If possible encourage them to bring their drinks to the discussion.

2.2.1 Introduction to group work

Materials

- Handout: *Instructions for group work: session 2.2.2*
- Handout: 2.2.1 *MAPM memory aid for participants*

Steps

a. Introduce the session objectives.

b. Explain the activities planned for the session and the time allotted for each activity using a prepared flipchart (see session agenda table above).

c. Go through the instructions for the group work activity using the handout.

Instructions for group work: session 2.2.2

1. *Participants will be divided into two or four groups:*

- ***Group 1*** *will focus on the outcome:* prevention of HIV among young people
- ***Group 2*** *will focus on the outcome:* prevention of too early or unwanted pregnancy among adolescents
- ***If there is a group 3*** *it will focus on the outcome:* prevention of HIV among young people
- ***If there is a group 4*** *it will focus on the outcome:* prevention of too early or unwanted pregnancy among adolescents.

2. *Each group should select a* chairperson *and a* rapporteur.

3. *Each group will develop a MAPM framework using cards:*

- ***White*** *cards for* interventions
- ***Pink*** *cards for* determinants
- ***Blue*** *cards for* behaviours.

Use the handout MAPM memory aid for participants *to help clarify* behaviours, determinants *and* interventions.

Groups will be told where they will be working.

Please move quickly to your groups; start your work by appointing a chairperson and rapporteur.

Remember:

- *Rapidly focus on only one or two behaviours.*
- *Identify the three most important related determinants.*
- *Specify related interventions.*

Please do not try to be exhaustive.

You have 40 minutes to complete this group work.

If you go for tea/coffee please return to the group work on time or, if possible, bring it with you to the group work.

d. Ask if there are any questions and respond.

2.2.2 Group work

Materials

- VIPP cards (white, pink, blue)

Steps

a. Give the chairperson of each group a set of VIPP cards (white, pink, blue).

b. At least one facilitator should join each group as a participant. The facilitator(s) should speak only when needed to help clarify the task, to help focus the group on the task, or to answer questions.

c. Carefully monitor the progress of the groups as they work.

d. Remind them of the flipchart.

e. Periodically tell the groups how much time is remaining.

2.2.3 Report back and wrap up

* (10 minutes per group if there are four groups)

Materials

Three different coloured VIPP cards with the headings “interventions”, “determinants” and “behaviours”

Note to facilitator

- If there is time do full reporting back now.
- If time is short, you can ask some or all groups to report only after reworking and completing the framework (i.e. in session 2.3.5), when they can report back on the changes they made after the determinants presentation, and the priorities that they identified.

Steps

a. Ask the groups to return to their plenary seats.

b. Pin up the VIPP cards with the headings “interventions”, “determinants” and “behaviours”.

c. Ask the first rapporteur to report back on the work of his or her group.

d. Help the rapporteur to hang the group’s VIPP cards under the appropriate headings.

e. When the rapporteur has finished, ask if his or her group would like to add or clarify anything.

f. Lead a brief discussion to further explore the framework that was presented: What is missing? What is the evidence?

g. Repeat the steps above for the second group. Do not take down the first group’s cards. Instead, continue to add the second group’s cards under the same headings, beside the first group’s cards.

h. If you have groups 3 and 4, they should report now. Ask them to only discuss new points that have not already been presented.

Session 2.3 A closer look at determinants

Agenda for a closer look at determinants	
00:05	2.3.1 Introduction
00:40	2.3.2 Presentation on determinants
00:15	2.3.3 Introduction to group work (followed by lunch)
00:40	2.3.4 Group work
00:30	2.3.5 Report back and wrap up
00:20	Participants' presentation time (optional)
02:30	

Session objectives

By the end of this session participants will be able to:

- Define the terms "risk" and "protective factors";
- Explain why it is important to classify determinants as risk or protective factors;
- Identify appropriate risk and protective factors for a specific health or development outcome;
- Prioritize risk and protective factors.

Preparation

Presentation

2.3.2 *Determinants*

Handouts

- *Instructions for group work: session 2.3.4*
- *Risk and protective factors that are feasible to change by programmes*
- *Questions at report back: session 2.3.5*

Other

Pink VIPP cards

Break

The break for lunch will take place before the group work.

2.3.1 Introduction

5 MIN

Materials

Handout: *Five-day agenda*

Steps

a. Introduce the session objectives using the handout.

b. Explain the activities planned for the session and the time allocated for each activity.

c. Ask the participants if they have any questions.

2.3.2 Presentation on determinants

40 MIN

Materials

Presentation: 2.3.2 *Determinants*

Steps

a. Present slides and go through talking points.

b. Stop where indicated to ask checking questions.

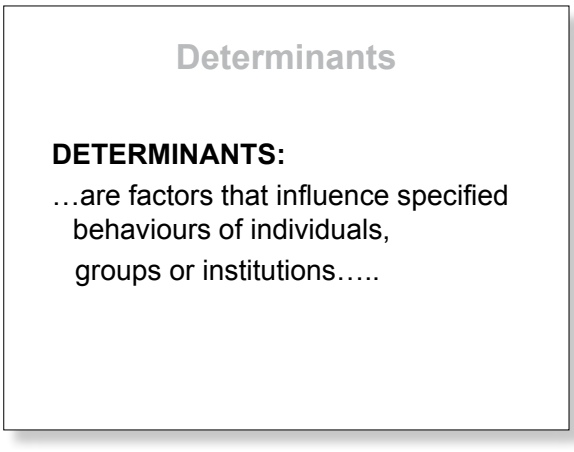
c. Give further explanations and examples in order to overcome any misunderstandings.

Talking points

Slide 1 Determinants

Any interventions designed to change behaviours must first change the determinants of these behaviours.

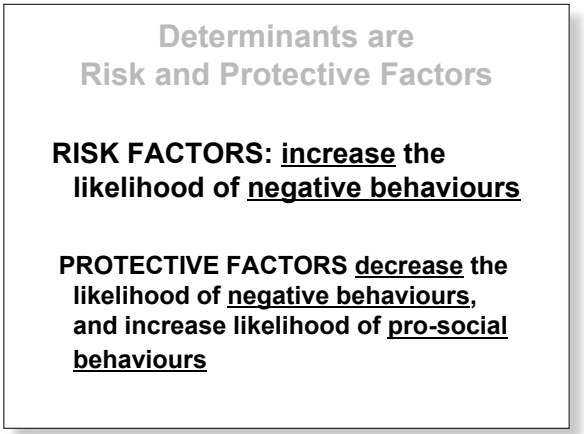
(Examples of other terms used for determinants are antecedent, precursor, pathway, variable, and independent variable.)



Slide 2 Determinants are risk and protective factors

These risk and protective factors are important to address in changing behaviours. Reducing only risk factors or increasing only protective factors can reduce programme effectiveness.

Programmes that focus only on risk factor reduction target mostly those young people who are engaging in risk behaviours (typically only 20–30% of all young people), or are about to do so. Focusing on increasing protective factors applies to *all* young people and also promotes positive behaviours as alternatives to negative behaviours.



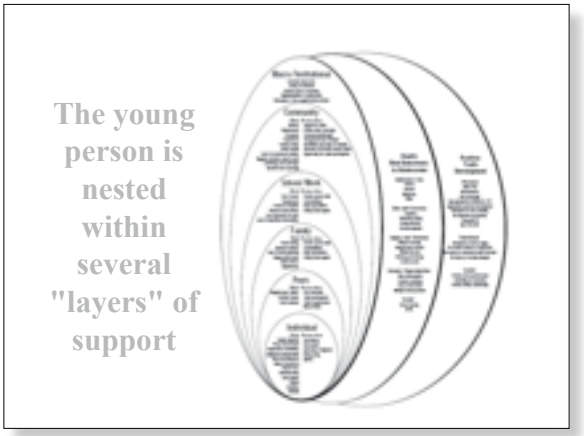
Slide 3 The young person is nested within several layers of support

Determinants describe characteristics of individuals and their peers, partners, families, schools, health services, community institutions, other community characteristics and government policies. These are shown in this diagram as layers of support around the adolescents.

Ideally determinants should be selected from several of these layers.

No single determinant exclusively changes a behaviour, though some are more causal in changing behaviours than others, as focused research would show.

Some determinants are also easier to change than others.

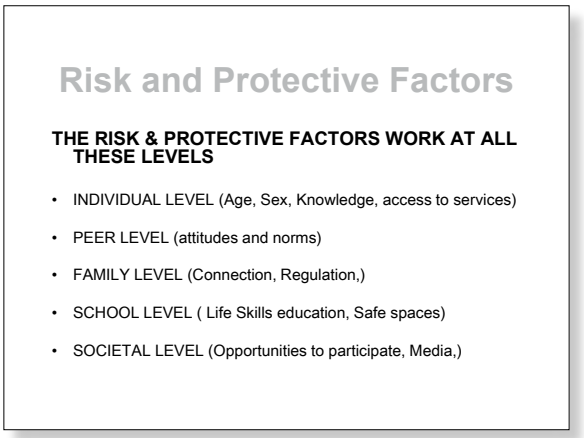


Slide 4 Risk and protective factors

Here are some examples of determinants that are risk factors and protective factors for unwanted pregnancies, within each of the layers shown in the previous slide.

But which determinants are to be selected in designing a programme?

- Confirm those that have a causal effect on behaviour change, from research.
- Of these determinants, which are also changeable by interventions?



Ask participants to open their handout *Risk and protective factors that are feasible to change by programmes*. Go through it with them.

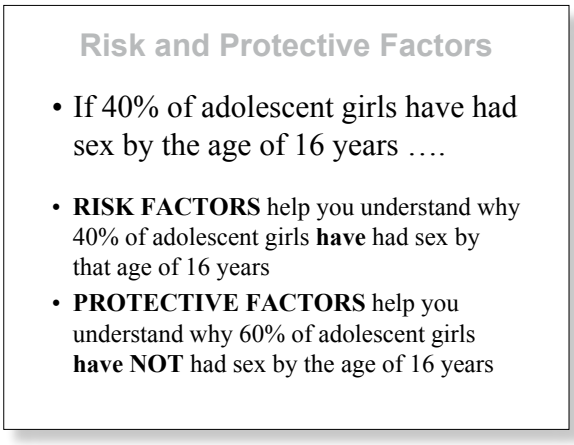
Slide 5 Risk and protective factors

Read the slide, then ask:

Question

- If we want to *decrease* the percentage of girls who have sex before the age of 16 years, then we should focus on which type of factors – risk factors or protective factors?

(Answer: We should focus on both types!)



Slide 6 What are risk factors?

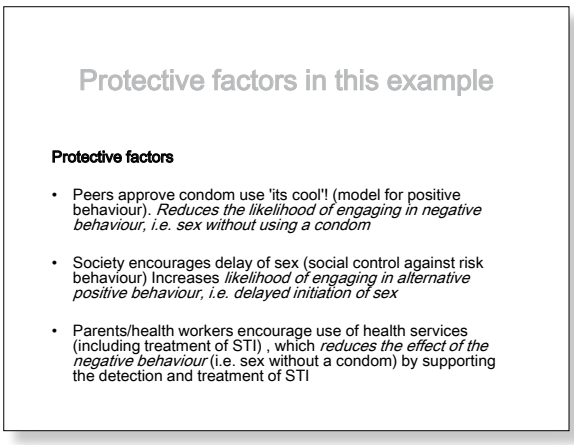
Question

- Can someone give me another example of a protective factor?

Slide 7 What are protective factors?

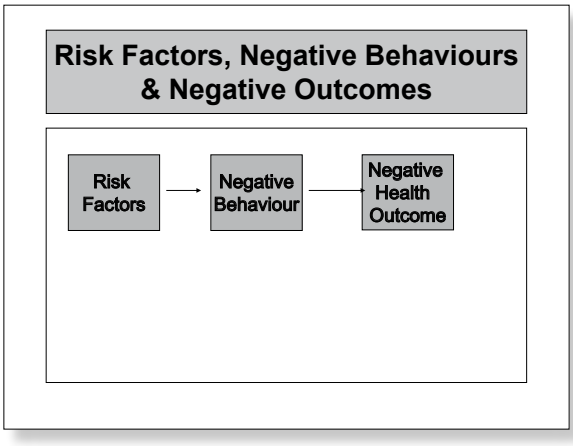
Question

- Can someone give me another example of a protective factor?



Slide 8 Risk factors, negative behaviours and negative outcomes

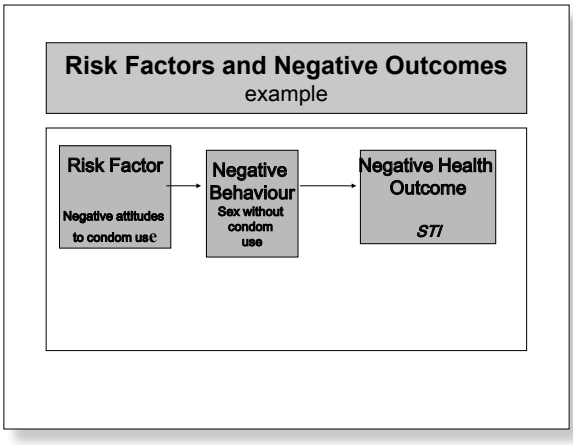
This diagram presents the role played by *risk factors* in influencing negative behaviours and the negative health outcomes that result.



Slide 9 Risk factors and negative outcomes: example

This is the same diagram with a simple example:

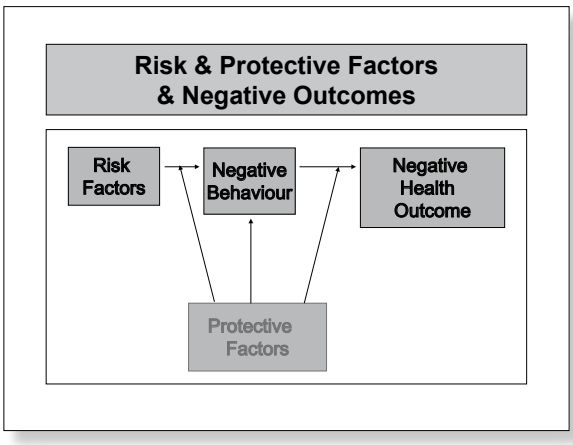
- risk factor: negative attitudes to condom use
- negative behaviour: unprotected sex
- negative health outcome: sexually transmitted infection.



Slide 10 Risk and protective factors and negative outcomes

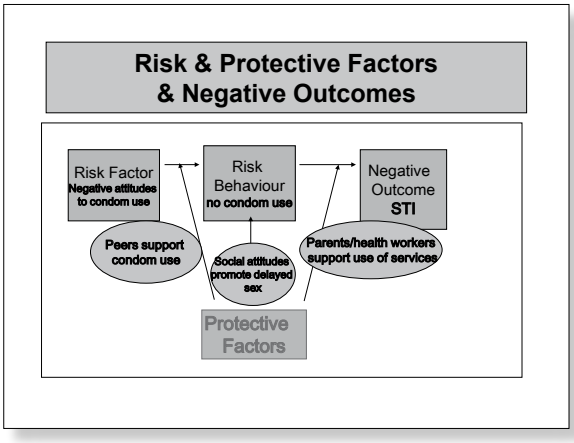
Unlike risk factors, which act only to enhance risk behaviours, protective factors act in three ways:

- they inhibit risk behaviours
- they promote positive behaviours
- they moderate the effect of undertaking risk behaviour.



Slide 11 Risk and protective factors and negative outcomes

Here is a diagram prepared by Richard Jessor that presents the differing roles played by *protective factors* and *risk factors* in mediating risk behaviours and the negative outcomes that result.



Slide 12 Protective factors in this example

Here you can see that the *protective factors*:

- reduce the likelihood of engaging in a negative behaviour (e.g. sex without a condom);
- provide alternative positive behaviour models (e.g. delayed initiation of sexual activity);
- provide the young person with an opportunity to get detection and treatment for a sexually transmitted disease that may result from sex without a condom.

Question

- If we had to prioritize these protective factors – or choose only one on which to focus – how would we do it?

(Response: Prioritize based on the likelihood of influencing the determinant. An intervention exists that can affect the determinant.)

2.3.3 Introduction to group work

15 MIN

Materials

Handout: *Instructions for group work: session 2.3.4*

Steps

a. Give the following instructions for the group work activity using a prepared flipchart.

Instructions for group work: session 2.3.4

Go to your previous groups: group 1 and group 2 (3, 4 etc.).

Look at the determinants on your pink cards.

For each determinant decide:

- *If you will keep it or revise it.*
  If you revise it, write the revised determinant on a new card.
- *If it is a risk factor or a protective factor, write either "risk" or "protective" on each pink card.*
- *If you would like to add any new determinants.*
  If yes, write a new card and mark it "risk" or "protective".

Prioritize your determinants. Write "1" on the first priority, "2" on second, and "3" on third.

You have 40 minutes to work together.

b. Ask if there are any questions.

c. Ask the rapporteur from each group to remove their group's pink "determinants" cards from the wall and take them to the group work.

d. Give the rapporteurs extra pink cards.

e. Ask the participants to quickly move to their groups and start working.

f. Remind participants that they have 40 minutes to complete the group work (or less if you are running late).

Participants should go to lunch at the assigned time and return to their groups to work after lunch.

2.3.4 Group work

Materials

Pink VIPP cards

Steps

a. At least one facilitator should join each group as a participant. The facilitator(s) should speak only when needed to help clarify the task, to help focus the group on the task, or to answer questions.

b. Carefully monitor the progress of the groups as they work.

c. Give suggestions to help the groups focus on the task and to progress.

d. Periodically tell the groups how much time is remaining.

2.3.5 Report back and wrap up

30 MIN

Materials

Handout: *Questions at report back: session 2.3.5*

Steps

a. Ask the groups to return to their plenary seats.

b. Ask the first rapporteur to place the group's pink cards back on the wall under the "determinants" heading (report back can be in reverse order, i.e. group 2 (or 3 or 4) first and then group 1).

c. Ask them to look at their instructions for group work *Questions at report back: session 2.3.5*.

d. Then ask the rapporteur to answer the following questions.

Questions at report back: session 2.3.5

- *Which determinants did the group revise? How? Why?*
- *Did you add new determinants? What? Why?*
- *Which determinants are "protective factors"?*
- *Which determinants are "risk factors"?*
- *Which are the "priority" determinants? How did you decide on the priorities? What criteria did you use?*

e. When the rapporteur has finished, ask if his or her group would like to add or clarify anything.

f. Repeat the steps above for the other group(s).

g. Ask participants to identify the common determinants for the two different outcomes.

h. Group the VIPP cards that are similar – under "behaviours", "determinants" and "interventions"– to create a combined MAPM framework for the reduction of HIV prevalence and the prevention of early or unwanted pregnancy.

i. Lead a short discussion to *explore the implications of a common framework* for the reduction of HIV prevalence and the prevention of early or unwanted pregnancies for programmes and policies in countries.

j. Summarize the lessons learnt from this exercise using the session objectives.

Participants' presentation time (optional)

20 MIN

Session 2.4 Planning for HIV and reproductive health programmes I

Agenda for planning HIV and reproductive health programmes I	
00:15	2.4.1 Introduction to group work
00:45	2.4.2 Group work
00:30	2.4.3 Report back
01:30	

Note to facilitator

In this activity participants will review a document or a project plan from their country (e.g. national HIV plan, national adolescent health plan, national reproductive health plan: chapter on adolescents). They will use the MAPM framework to determine if the plan identifies the health outcomes, behaviours and determinants that the project aims to affect.

It is useful to include an example of a strong and a weak plan in the materials.

The way the working groups are divided will depend on the documents that are being reviewed. If participants can be linked to a document or a plan that is selected they can be divided into working groups in this way. More than one group can work on the same document.

Participants may be reviewing or revising an existing plan but they are not to develop a new plan. If a group is working on their own plan they can use the activity to revise the plan; however, this is not the objective of this activity.

Session objectives

By the end of this session participants will be able to:

- State the desired health and development outcomes of participants' selected plans (national, regional, state, organizational, other);
- List key behaviours related to those health outcomes;
- Describe the determinants (risk and protective factors) of the priority behaviours (i.e. factors that influence adolescents to engage in each priority behaviour);
- Prioritize the determinants.

Preparation

Plan how participants will be divided into the working groups. This will depend on the documents being reviewed and the profile of the participants.

Handouts

Instructions for group work: session 2.4.2

MAPM memory aid for participants

2.4.1 Introduction to group work

Materials

- Handout: *Five-day agenda*
- Handout: *Instructions for group work: session 2.4.2*
- Handout: *MAPM memory aid for participants*

Steps

a. Go through the session objectives in the handout.

b. Explain the activities planned for the session and the time allotted for each activity.

c. Give participants the handout *Instructions for group work: session 2.4.2* and go through the instructions with them.

Instructions for group work: session 2.4.2

The group should work together using the following instructions.

Appoint a chairperson and a rapporteur.

Write your responses to the questions and the question number on the flipchart, which the rapporteur will use to present in plenary.

Review the document quickly*, focusing on:*

- *sections of the text that deal with the situation analysis (problem statement);*
- *proposed strategies and activities (proposed solutions);*
- *proposed monitoring indicators.*

1. *Does the plan clearly identify:*
   - *the health outcomes it tries to influence?*
   - *the health behaviours that most affect these outcomes?*
   - *the determinants of these behaviours?*
   - *the interventions that link to these determinants?*

2. *When you analyse the plan with the MAPM framework in mind, do you think the plan is a clear logical plan, with interventions that are logically linked to changes in health outcomes or behaviours? If not, what seem to be the underlying assumptions?*

3. *In your opinion, were there important behaviours or determinants missing in the (analysis of the) plan?*

4. *Look at the proposed monitoring and evaluation indicators of the plan.*
   - *Are there measures for all the columns of the MAPM framework?*
   - *In your opinion, are they useful indicators to track the implementation and the effects?*

d. Remind participants to use the handout *MAPM memory aid for participants* from the previous session.

e. Ask the participants if they have any questions.

f. Read out the names of the participants in each group.

g. Tell the participants which document each group will review and allocate the area they will work on.

h. Ask the participants to quickly go to their groups, appoint their chairperson and rapporteur, and begin working.

i. Remind participants that they have 45 minutes to complete the group work.

2.4.2 Group work

45 MIN

Materials

- Handout: *Instructions for group work: session 2.4.2*
- Handout: *MAPM memory aid for participants*
- Blank flipchart for each group to record working group feedback

Steps

a. Carefully monitor the progress of the groups as they work.

b. Give suggestions to help the groups focus on the task and to progress.

c. Periodically tell the groups how much time is remaining.

2.4.3 Report back

30 MIN

Note to facilitator: Decide how long each group will have to report back. This will depend on the number of working groups and the number of plans that have been reviewed. If groups have reviewed the same plan, then the second group may shorten their presentation if points have already been identified by the first group, e.g. "We agree with the first group on…"

Materials

Flipcharts from each working group

Steps

a. Ask the groups to return to their plenary seats.

b. Help the first rapporteur to display his or her group's flipchart.

c. Ask the first rapporteur to report back on the responses to the questions from his or her working group.

d. Repeat the steps above for the second (third and fourth) group.

e. Summarize the responses.

f. Ask participants if the MAPM framework helped them to review the plans.

Session 2.5 Day 2 wrap-up

Materials

Flipchart 15 *Personal diary questions*

Steps

a. Ask participants to open the book that they are using as their personal diary.

b. Go through the two points on the flipchart (the same flipchart as for day 1 wrap-up).

FLIPCHART 15 Personal diary questions

1. *What did you find particularly useful today? List up to three things.*

2. *List three things you would like to do (differently) in your day-to-day work as a result of what you learnt today.*

c. Ask if there are any questions.

d. Ask them to write their responses in their diary.

e. Go through the agenda for tomorrow in the handout *Five-day agenda* to prepare participants for the next day.

f. Thank the participants for their hard work today and say we will begin again at 8.30 tomorrow morning.

Day 2 Handouts:

- *Session 2.1* Mapping adolescent programming and measurement
- *Session 2.2.2* Instructions for group work
- *Session 2.3* Risk and protective factors that are feasible to change by programmes
- *Session 2.3.4* Instructions for group work
- *Session 2.3.5* Questions at report back
- *Session 2.4.2* Instructions for group work

HANDOUT

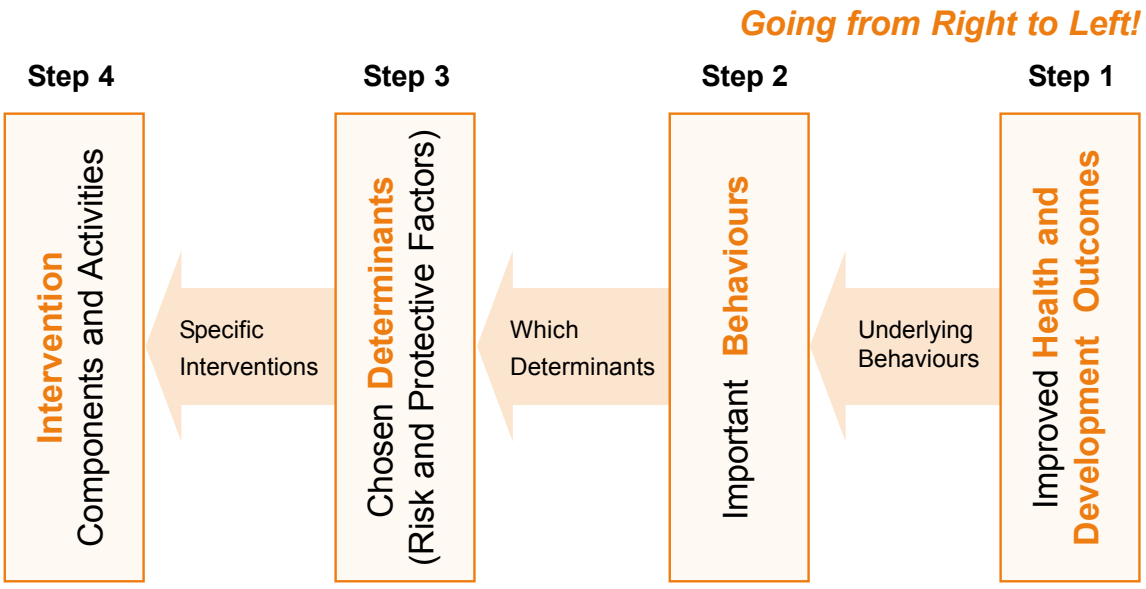
Session 2.1 Mapping adolescent programming and measurement

Background and Rationale

As programmes for young people expand in countries it is important for programme managers to be able to make rational choices for selecting interventions that have an effect on the key determinants of health outcomes of interest, e.g. reduction in HIV or maternal mortality. To assist them, the Department of Child and Adolescent Health (CAH) of the WHO has developed a tool to support the design, review and measurement of programmes aiming to improve adolescent health and development. This tool, the Mapping Adolescent Programming and Measurement framework (MAPM), was developed with the United Nations Children's Fund (UNICEF) and 24 countries across the world.

Using MAPM

Application of the MAPM framework allows programme managers to specify which behaviours and their determinants they are currently addressing or intend to address, through intervention activities. The process includes four steps (see diagram below) to clarify the health outcomes, behaviours and determinants (i.e. the risk and protective factors) in that order, that can be influenced through intervention activities (defined in the fourth step). Specifying risk and protective factors is important for defining subsequent intervention activities, but also to identify intermediate outcomes to be monitored. It should be noted that the determinants are identified based on research evidence that they are linked to the desired behaviours and are themselves feasible to change through intervention activities.



Expected Outcomes from using MAPM

The MAPM framework can be used to:

- review existing programmes to determine if the interventions in place can be expected to achieve the desired behavioural and health and development outcomes;
- identify important risk and protective factors (selected determinants of desired behaviours) to monitor as intermediate outcomes;
- define the key indicators for each of the four steps in the process of reviewing existing programmes or designing new programmes;
- organize the assessment of programmatic indicators (quality, coverage and cost of activities) prior to monitoring risk and protective factors, before monitoring key behaviours and health outcomes the interventions are intended to change; it can reduce pressure to demonstrate effects on health and development outcomes, which are difficult to do in a short period of time (i.e. five years).

HANDOUT

Session 2.2.2 Instructions for group work

1. You will be divided into two or four groups:

- **Group 1** will focus on the outcome: *prevention of HIV among young people*
- **Group 2** will focus on the outcome: *prevention of too early or unwanted pregnancy among adolescents*

- **If there is a group 3** it will focus on the outcome: *prevention of HIV among young people*
- **If there is a group 4** it will focus on the outcome: *prevention of too early or unwanted pregnancy among adolescents.*

2. Select a *chairperson* and a *rapporteur* for each group.

3. Each group will develop a MAPM framework using cards:

- **White** cards for *interventions*
- **Pink** cards for *determinants*
- **Blue** cards for *behaviours.*

Use your handout *MAPM memory aid for participants* to help clarify *behaviours*, *determinants* and *interventions.*

You will be told where your group will be working.

Please move quickly to your groups; start your work by appointing a chairperson and rapporteur.

Remember:

- Rapidly focus on only one or two behaviours.
- Identify the three most important related determinants.
- Specify related interventions.

Please do not try to be exhaustive.

You have 40 minutes to complete this group work.

If you go for tea/coffee please return to the group work on time or, if possible, bring it with you to the group work.

HANDOUT

Session 2.3 Risk and protective factors that are feasible to change by programmes[1]

Risk and protective factors[2]	Feasibility of change[3]	Comments on feasibility of possible programmes to change risk and protective factors
A. Environmental factors		
STATE		
Support for family planning		
+ Higher level of state funding for family planning	**	Although it is difficult for any single agency to significantly affect state funding, given that family planning is their topic area, pregnancy prevention organizations may be able to join other organizations with similar missions and encourage their state to increase funding for family planning.
COMMUNITY		
Community disadvantage and disorganization		
+ High level of education	*	In general, pregnancy and sexually transmitted infection (STI) prevention programmes, themselves, do not have the resources or capability for markedly changing community-wide rates of education, employment, income, crime or overall quality. However, pregnancy and STI prevention programmes can work collaboratively with other organizations to address poverty and disorganization in communities.
– High unemployment rate	*	
+ High income level	*	
– High social disorganization and crime rate	*	
+ High neighbourhood quality	*	
FAMILY		
Structure and economic advantage of the adolescents' families		
+ Live with two parents (vs one parent or step-parents)	*	In general, pregnancy and STI prevention programmes cannot affect the marital status and living arrangements of families. However, if their agencies have marriage or family counselling departments, then these departments may be able to help parents stay together.
+ Live with one parent (vs none)	*	
– Divorce among parents	*	

[1] Adapted with permission from: Kirby D, Lepore G and Ryan J. *Sexual risk and protective factors. Factors affecting teen sexual behavior, pregnancy, childbearing and sexually transmitted disease: Which are important? Which can you change?* San Francisco, ETR Associates, 2005. (http://www.health.state.nm.us/phd/fp/Forms/risk%20and%20protective%20factorsExecsummary_kirby.pdf, accessed 25 May 2010)

[2] Plus sign indicates protective factors; minus sign indicates risk factors.

[3] * = Extremely difficult for most pregnancy and sexually transmitted infection (STI) prevention agencies to change directly themselves, although they may have a long-term effect by working with other agencies to change policies.
** = Difficult for most pregnancy and STI prevention agencies to change unless they have special programmes or capabilities.
*** = Most amenable to change directly by pregnancy and STI prevention agencies.

Risk and protective factors[2]	Feasibility of change[3]	Comments on feasibility of possible programmes to change risk and protective factors
+ High level of parents' education	*	In general, pregnancy and STI prevention programmes cannot affect the parents' educational level. However, in some communities, programmes with a holistic approach may be able to provide guidance and counselling to parents and encourage and facilitate their obtaining a higher education.
+ High parental income level	*	In general, pregnancy and STI prevention programmes cannot affect the parents' income level. However, in some communities, agencies that also work with adults may be able to provide guidance and counselling to parents, encourage them to increase their education, and provide guidance for obtaining jobs or higher-income jobs.
– Large family size (more siblings)	**	Some family planning agencies may have some impact on completed family size.
– Being a younger (vs older) sibling	*	Programmes cannot affect birth order of young people.
Family religiosity		
+ Greater family religiosity	*	In general, pregnancy and STI prevention programmes, themselves, do not have the mission or the resources to increase religiosity in families.
Positive family dynamics and attachment		
+ Living with parents	*	In general, pregnancy and STI prevention programmes can have little effect on whether youths live with their parents, or on family support, communication and connectedness. However, some agencies may be able to provide intensive family guidance and counselling and may be able to have an impact on these family interactions.
+ Greater family support	**	
+ Greater communication in general	**	
+ High-quality family interactions and connectedness	**	
+ Appropriate parental supervision and monitoring	**	Some more holistic programmes may be able to implement programmes for parents that encourage them to supervise and monitor their adolescent children appropriately.
– Physical abuse and general maltreatment	**	In general, pregnancy and STI prevention programmes can have little effect on physical abuse and maltreatment within the family. However, some agencies may be able to provide intensive family guidance and counselling and may be able to have an impact on these behaviours.
Family modelling of non-sexual risk behaviours		
– Household substance abuse (alcohol and drugs)	**	In general, pregnancy and STI prevention programmes can have little effect on whether parents of adolescents abuse alcohol or drugs. However, some agencies may be able to provide alcohol and drug abuse prevention programmes and thereby reduce parental abuse.

Risk and protective factors[2]	Feasibility of change[3]	Comments on feasibility of possible programmes to change risk and protective factors
Family attitudes about and modelling of sexual risk taking and early childbearing		
– Mother's early age at first sex and first birth	*	Programmes cannot affect the adolescents' mothers' prior behaviour. However, programmes can prevent current adolescents from becoming adolescent mothers, and thereby help the next generation.
+ Parental disapproval of premarital sex or adolescent sex	**	Pregnancy and STI prevention programmes can provide parents with accurate information about adolescent sexual behaviour and its consequences. Some programmes, especially church-based programmes, may emphasize conservative religious values about premarital sex and adolescent sex. Many programmes may encourage parents to encourage their adolescents to be abstinent.
+ Parental support for contraceptive use if sexually active	**	Pregnancy and STI prevention programmes can provide parents with accurate information about adolescent sexual behaviour, its consequences, and the effectiveness of condoms and contraception. Some programmes may be willing to encourage parents to encourage their adolescents to use contraception if they do have sex.
– Older sibling's early sexual behaviour and early age of first birth	**	In general, pregnancy and STI prevention programmes cannot affect the previous behaviour of older siblings. However, they can, of course, affect the behaviour of current adolescents who may have younger siblings.
Communication about sex and contraception		
+ Greater communication about sex and condoms or contraception before youth initiates sex	***	Pregnancy and STI prevention programmes can increase parent–child communication about sex, condoms and contraception through school homework assignments, special programmes for parents, college courses for parents, and other approaches.
SCHOOL		
School characteristics		
+ Private religious (vs public) school	*	In general, pregnancy and STI prevention programmes cannot address whether students attend public versus private religious schools.
+ Provides sex or HIV education	***	Many pregnancy and STI prevention programmes can implement effective sex and HIV education programmes.
PEER		
Peer attitudes and behaviour		
– Peers' alcohol use, drug use and deviant behaviour	**	If friends can be reached by programmes, then some pregnancy and STI prevention programmes with a youth development emphasis may be able to implement effective drug prevention programmes and other effective youth development programmes that reduce non-normative behaviour.
– Permissive values about sex and early childbearing	***	If friends can be reached by programmes, then agencies can implement effective abstinence-only or sex and HIV education programmes that change permissive values about sexual behaviour and delay the initiation of sex. If peers cannot be reached in the programme, then programmes can implement activities in small or large group settings that demonstrate peer support for delaying sex and avoiding pregnancy.

Risk and protective factors[2]	Feasibility of change[3]	Comments on feasibility of possible programmes to change risk and protective factors
+ Positive peer norms or support for condom or contraceptive use	***	If friends can be reached by programmes, then agencies can implement effective sex and HIV education programmes or effective clinic protocols that increase support for condom and contraceptive use and actually increase condom and contraceptive use. If peers cannot be reached, then programmes can implement activities in small or large group settings that demonstrate peer support for condom and contraceptive use if sexually active.
– Sexually active peers	***	If friends can be reached by programmes, then agencies can implement effective abstinence-only or effective sex and HIV education programmes that change permissive values about sexual behaviour and delay the initiation of sex. If friends cannot be reached, then programmes can implement activities demonstrating that perceptions of peer sexual activity are typically exaggerated.
– Good friends who are pregnant or parenting	***	If friends can be reached by programmes, then agencies can implement effective abstinence-only education, sex and HIV education, effective family planning clinic protocols, or youth development programmes that reduce sexual risk taking and pregnancy.
ROMANTIC PARTNER		
Partner characteristics		
– Having a romantic partner who is older	**	Pregnancy and STI prevention programmes can encourage youths to date people their own age and not older. However, such efforts have not yet been evaluated.
+ Partner support for condom and contraceptive use	**	If partners can be reached by programmes, then effective sex and HIV education programmes can be implemented.
B. Adolescent individual factors		
Biological factors		
– Being male	*	Within reason, it is not possible to change these biological factors.
– Older age and greater physical maturity	*	
– Higher testosterone levels	*	
Race/ethnicity		
– Being black (vs white)	*	Programmes cannot affect the race or ethnicity of people. However, sometimes, in collaboration with other groups, they can help reduce minority poverty or affect minority cultural values that may contribute to sexual risks.
– Being Hispanic (vs non-Hispanic white)	*	

Risk and protective factors[2]	Feasibility of change[3]	Comments on feasibility of possible programmes to change risk and protective factors
Attachment to and success in school		
+ Enrolment in school	**	Some pregnancy and STI prevention programmes with a youth development emphasis may be able to implement tutoring programmes, mentoring programmes, job shadowing, intensive arts programmes, sports, or service learning or other programmes that may help keep youths in school, keep them involved, improve their grades and improve their future aspirations.
+ Participation and involvement in school and school activities	**	
+ School connectedness	**	
+ Higher academic performance	**	
+ High educational aspirations and plans for the future	**	
Attachment to faith communities		
+ Having a religious affiliation and attending frequently	**	Most pregnancy and STI prevention programmes cannot strive to increase involvement in religious organizations. However, faith communities can implement youth programmes or initiatives that may increase youths' involvement and faith communities can implement programmes to help youths better understand their religions' values about sexuality.
+ Greater religiosity	**	
+ Conservative or fundamentalist religious affiliation	**	
Attachment to other community organizations or adults		
+ Connected to or involved with other adults or organizations in the community	**	Some pregnancy and STI prevention programmes with a youth development emphasis may be able to implement tutoring programmes, mentoring programmes, job shadowing, intensive arts programmes, sports, or service learning or other programmes that may help keep youths in school, keep them involved, improve their grades and improve their future aspirations.
Involvement in gangs		
– Being part of a gang	**	Some pregnancy and STI prevention programmes with a youth development emphasis may be able to implement programmes that reduce gang membership.
Problem or risk-taking behaviours		
– Alcohol use	**	Some pregnancy and STI prevention programmes with a youth development emphasis may be able to implement effective alcohol and drug prevention programmes and other effective youth development programmes that reduce alcohol use, drug use, aggression, sensation-seeking behaviours and other non-normative behaviour.
– Drug use	**	
– Problem behaviours or delinquency	**	
– Hostility and aggression	**	
– Greater sensation-seeking behaviour	**	
– Other risk behaviours	**	

Risk and protective factors[2]	Feasibility of change[3]	Comments on feasibility of possible programmes to change risk and protective factors
Other behaviours		
– Paid work	**	Most pregnancy and STI prevention programmes will not wish to discourage youths from working and having the greater autonomy that accompanies work. However, some may provide employment opportunities in more supervised settings that may also discourage risk-taking behaviour.
+ Involvement in sports (females only)	**	Some pregnancy and STI prevention programmes with a youth development emphasis may be able to implement sports programmes for girls.
+ Involvement in other healthful behaviours	**	Some programmes with a youth development focus may be able to improve a variety of healthful behaviours.
Emotional well-being and distress		
+ Higher self-esteem and self-concept (possibly girls only)	**	Self-esteem is very difficult to change. However, some programmes with an intensive youth development focus may be able to increase self-esteem.
+ Greater internal locus of control	**	Internal locus of control is difficult to change. However, some programmes with an intensive youth development focus may be able to improve locus of control.
– Depression	**	Most pregnancy and STI prevention programmes are not equipped to deal with severe adolescent depression. However, some programmes may be able to refer youths to other agencies to obtain needed help or may provide these services in-house.
Relationship with romantic partners		
– Early and frequent dating	**	Pregnancy and STI prevention programmes can encourage parents to appropriately monitor and supervise early dating. Programmes can also encourage youths to delay dating or to participate in group activities rather than one-on-one dates. Such efforts have not been evaluated, however.
– Going steady, having a close relationship	**	
– Greater number of romantic and sexual partners	**	
– Greater number of sexual partners	***	Pregnancy and STI prevention programmes can implement effective sex and HIV education programmes and clinic protocols that target these factors and have been demonstrated to reduce the number of sexual partners and increase communication about sexual risks and pregnancy and STI prevention.
+ Discussion of sexual risks with partner	***	
+ Discussion of pregnancy and STI prevention	***	
– Being married	**	Most programmes do not include delaying marriage in their mission. However, some programmes, especially those with counselling components, may be able to get some young people to think seriously about the implications of marriage, before they get married.
Sexual beliefs, attitudes and skills		
+ Less stereotypical gender roles	**	Internalized gender roles are not easy to change. However, some programmes, especially those with a broader focus, may be able to get some adolescents to questions some of their gender roles, especially those related to sexual behaviour and contraceptive use.

Risk and protective factors[2]	Feasibility of change[3]	Comments on feasibility of possible programmes to change risk and protective factors
+ Knowledge of HIV	***	Pregnancy and STI prevention programmes can implement effective abstinence-only education programmes, sex and HIV education programmes, and clinic protocols that target these factors and have been demonstrated to delay the initiation of sex, reduce the frequency of sex and the number of partners, and increase condom or contraceptive use.
+ Attitudes favouring abstinence until marriage	***	
+ More perceived benefits of abstaining from sex and fewer perceived costs of having sex	***	
+ Greater perceived susceptibility to pregnancy, or STI/HIV	***	
+ Greater perceived negative consequences of pregnancy, childbearing and STI	***	
+ Greater motivation to avoid pregnancy, childbearing and STI	***	
– Motivation to have a child or ambivalence about having a child	***	
+ Greater self-efficacy to abstain from sex	***	
– Intention to have sex	***	
+ Greater knowledge about condoms and contraception	***	
+ Belief that condoms are effective at preventing pregnancy and STI including HIV	***	
+ More positive attitudes about condoms	***	
+ Fewer perceived costs and barriers to using condoms (e.g. do not reduce pleasure and are not a hassle)	***	
– Greater perceived embarrassment using condoms	***	
+ Greater perceived male responsibility for pregnancy prevention	***	
+ More positive attitudes toward contraception	***	
+ Greater perceived negative consequences of pregnancy	***	

Risk and protective factors[2]	Feasibility of change[3]	Comments on feasibility of possible programmes to change risk and protective factors
+ Greater motivation to use condoms and contraception	***	Pregnancy and STI prevention programmes can implement effective abstinence-only education programmes, sex and HIV education programmes, and clinic protocols that target these factors and have been demonstrated to delay the initiation of sex, reduce the frequency of sex and the number of partners, and increase condom or contraceptive use.
+ Greater perceived self-efficacy to use condoms or contraception	***	
+ Intention to use condoms or contraception	***	
Previous sexual behaviours		
– History of prior sexual coercion or abuse	*	Logically, pregnancy and STI prevention programmes cannot prevent events that happened in the past and typically they are not equipped to prevent subsequent abuse or to properly address the consequences of previous sexual abuse. However, they can refer sexually abused youths to intensive and skilled counselling services for sexually abused youths, if they exist, and some agencies may be equipped to implement support groups for victims of abuse.
– Same-sex attraction or behaviour	**	Pregnancy and STI prevention programmes cannot affect whether youths are gay or lesbian, but some programmes designed for gay, lesbian and questioning youths may be able to reduce their sexual risk taking.
+ Older age of first sex	***	Pregnancy and STI prevention programmes can implement effective abstinence-only education programmes and sex and HIV education programmes that target these factors and have been demonstrated to delay the initiation of sex.
– Greater frequency of sex	***	Pregnancy and STI prevention programmes can implement effective abstinence-only education programmes and sex and HIV education programmes that target these factors and have been demonstrated to reduce the frequency of sex.
+ Previous effective use of condoms or contraception	***	Pregnancy and STI prevention programmes can implement effective sex and HIV education programmes, and clinic protocols that target and increase condom and contraceptive use.

HANDOUT

Session 2.3.4 Instructions for group work

Go to your previous groups: Group 1 or 2 (*3, 4*).

Look at the determinants on your pink cards.

For each determinant decide:

- If you will keep it or revise it.
  If you revise it, write the revised determinant on a new card.
- If it is a risk factor or a protective factor, write either “risk” or “protective” on each pink card.

If you would like to add any new determinants, write a new card and also mark it “risk” or “protective”.

Prioritize your determinants. Write “1” on the first priority, “2” on second, and “3” on third.

You have 40 minutes to work together.

HANDOUT

Session 2.3.5 Questions at report back

- Which determinants did the group revise? How? Why?
- Did you add new determinants? What? Why?
- Which determinants are “protective factors”?
- Which determinants are “risk factors”?
- Which are the “priority” determinants? How did you decide on the priorities? What criteria did you use?

HANDOUT

Session 2.4.2 Instructions for group work

The group should work together using the following instructions.

Select a chairperson and a rapporteur.

Write your responses to the questions and the question number on the flipchart, which the rapporteur will use to present later in plenary.

Review the document *quickly*, focusing on:

- sections of the text that deal with the situation analysis (problem statement)
- proposed strategies and activities (proposed solutions)
- proposed monitoring indicators.

1. Does the plan clearly identify:

- the health outcomes it tries to influence?
- the health behaviours that most affect these outcomes?
- the determinants of these behaviours?
- the interventions that link to these determinants?

2. When you analyse the plan with the MAPM framework in mind, do you think the plan is a clear logical plan, with interventions that are logically linked to changes in health outcomes or behaviours? If not, what seem to be the underlying assumptions?

3. In your opinion, were there important behaviours or determinants missing in the (analysis of the) plan?

4. Look at the proposed monitoring and evaluation indicators of the plan.

- Are there measures for all the columns of the MAPM framework?
- In your opinion, are they useful indicators to track the implementation and the effects?

Notes

DAY 3:
Strategic approaches for addressing priority health and development issues

Detailed agenda for day 3

Time	Minutes	Sessions and activities (minutes)	Materials
08:30	20	Administrative issues, flashback and agenda for day 3	**Flipchart** Flipchart 17 *Day 3 flashback* **VIPP cards** One VIPP card for each participant
08:50	45	**3.1 Global goals and targets** 3.1.1 Introduction (5) 3.1.2 Presentation on global goals and targets (15) 3.1.3 Discussion and wrap up (25)	**Presentation** 3.1.2 *Global goals and targets* **Handouts** Copies of the key documents related to global goals and targets **Flipchart** Flipchart 18 *Discussion questions for 3.1.3*
09:35	25	**3.2 Strategic framework for programming** 3.2.1 Introduction (5) 3.2.2 Presentation of the strategic framework for programming (20)	**Presentation** 3.2.2 *Setting the scene: a strategic framework for programming* **Handout** *Instructions for group work: session 3.2.4* **Flipchart** Flipchart 19 *Framework for programming for young people*
10:00	30	Break	
10:30	80	3.2.3 Introduction to group work (10) 3.2.4 Group work (30) 3.2.5 Report back and wrap up (40)	
11:50	40	**3.3 The role of the health sector** 3.3.1 Introduction (5) 3.3.2 Presentation on the role of the health sector (15) 3.3.3 Discussion and wrap up (20)	**Presentation** 3.3.2 *Defining priorities for action: the role of the health sector*
12:30	30	**3.4 Strategic information** 3.4.1 Introduction (5) 3.4.2 Interactive presentation on strategic information (25)	**Presentation** 3.4.2 *Strategic information* **Flipchart** Flipchart 20 *Discussion question 3.4.3* **VIPP cards** VIPP cards with the headings "interventions", "determinants", "behaviours" and "outcomes"
13:00	60	Lunch	
14:00	50	3.4.2 (continued) (25) 3.4.3 Discussion and wrap up (25)	

Time	Minutes	Sessions and activities (minutes)	Materials
14:50	40	 Participants' presentation time (optional) (20) **3.5 Strategic information for programme monitoring and evaluation** 3.5.1 Introduction (5) 3.5.2 Presentation on measuring interventions (15)	**Presentation** 3.5.2 *Measuring interventions* **Handout** *Instructions for group work: session 3.5.4* **Other materials** Two handouts (see session)
15:30	30	Break	
16:00	90	 Participants' presentation time (optional) (20) 3.5.3 Introduction to group work (10) 3.5.4 Group work (30) 3.5.5 Report back and wrap up (30)	
17:30	15	**3.6 Day 3 wrap-up**	**Flipchart** Flipchart 15 *Personal diary questions*

Administrative issues, flashback and agenda for Day 3

Materials

- Flipchart 17 *Day 3 flashback*
- One VIPP card for each participant

Steps

a. Administrative issues

- Make necessary announcements related to administration or logistics (e.g. meals, transportation, lodging, fees or per diems, or any other matter that was identified by the course facilitators or participants).
- Ask the participants if they have any questions. If you cannot answer quickly, schedule a time for further discussion (e.g. break, end of day), or tell the participant whom they should contact for a response.

b. Flashback

- Give each participant a blank VIPP card and distribute marker pens.

- Show Flipchart 17:

FLIPCHART 17 Day 3 flashback

Think about yesterday and write on your card:

One thing I liked about yesterday

or

One thing I did not *like about yesterday*

- Remind participants what the VIPP rules are.
- Tell participants that they have 30 seconds to write on their cards.
- Tell them that when they are finished writing to put their cards face down on a chair in the centre of the room. Gather the cards.
- Ask two volunteers to read out one card at a time and get the participants to decide if this is a negative or positive thought or feeling. They may also decide on an extra column for neutral thoughts or feelings.
- Stick the VIPP cards on the flipchart in two or three columns, clustering similar cards.
- Review the responses and thank the participants.

c. Agenda

- Go through the agenda for day 3 using the handout *Five-day agenda*. Remind participants that we will refer to the *Five-day agenda* handout during the introduction to each new session to read the session objectives.
- Summarize the sessions for the day.
- If there are any changes from the written agenda, explain them.

Session 3.1 Global goals and targets

Agenda for global goals and targets	
00:05	3.1.1 Introduction
00:15	3.1.2 Presentation on global goals and targets
00:25	3.1.3 Discussion and wrap up
00:45	

Session objectives

By the end of this session participants will be able to:

- Describe the international goals and targets that affect programming for adolescent health and development;
- Explain the relevance of global goals and targets to the participants' work;
- Explore how international goals could be translated into national goals;
- Identify other goals, at national or international level, that support adolescent health and development.

Preparation

Presentation

3.1.2 *Global goals and targets*

Flipchart

Flipchart 18 *Discussion questions for 3.1.3*

Handouts

Copies of the key documents related to global goals and targets (displayed at the side of the room for participants to look at later)

3.1.1 Introduction

Materials

Handout: *Five-day agenda*

Steps

a. Go through the session objectives with the participants using their handout.

b. Ask if the participants have any questions.

3.1.2 Presentation on global goals and targets

15 MIN

Materials

- Presentation: 3.1.2 *Global goals and targets*
- Copies of the key documents related to global goals and targets (displayed at the side of the room for participants to look at later)

Steps

a. Show Presentation 3.1.2 *Global goals and targets*.

b. Go through the talking points.

c. Give further explanations and examples in order to overcome misunderstandings.

d. Identify copies of the key documents related to global goals and targets.

Talking points

Slide 1 Why focus on young people?

On the first day of this course, we identified a number of good reasons for focusing on young people.

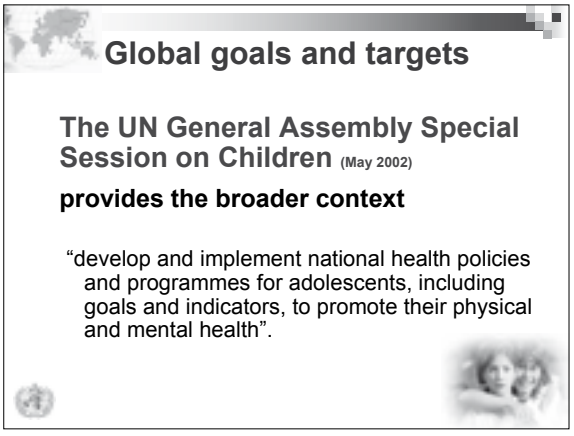
Question

- What are some of the reasons we discussed for focusing on young people?

Yes, in general terms they included … (read out slide and give examples for each area).

Slide 2 Global goals and targets

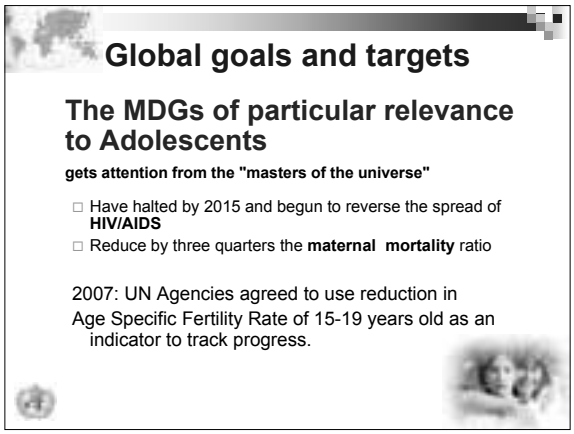
If we focus on global goals and targets, the results of the United Nations General Assembly Special Session on Children have provided the broader context.



Slide 3 Global goals and targets

In 2000, more than 189 nations committed themselves to the eight Millennium Development Goals (MDGs) and their related targets. The MDGs acknowledge the key role of the health sector, as well as the need for simultaneous action across many different sectors or fronts – such as education, social welfare, health, legislation, housing and transportation – for achieving social and economic development.

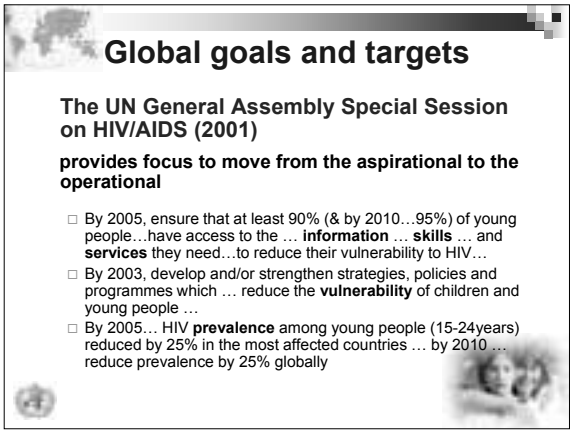
Three of the eight MDGs are of particular relevance to adolescents.



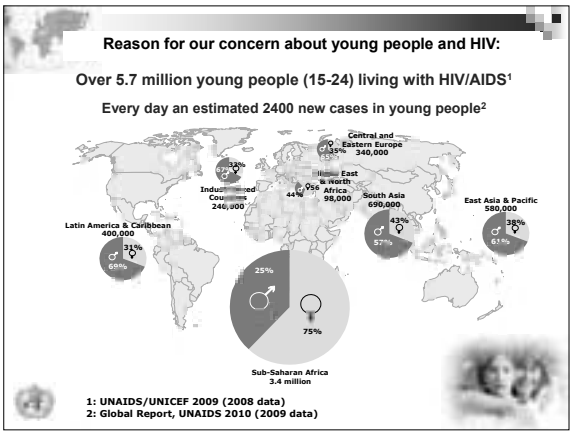
In 2007 United Nations agencies agreed to use the reduction in age-specific fertility rates of 15–19-year-olds as an indicator to track progress.

Slide 4 Global goals and targets

The outcome of the United Nations General Assembly Special Session on HIV/AIDS in 2001.



Slide 5 Reasons for our concern about young people and HIV



Estimates by the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the WHO indicate that by 2009 over 30 million people were infected with HIV.

Around the world, in 2008, 40% of the 2.7 million new infections occurred in 15–24-year-olds. *This means that about 2400 young people become infected every day.*

Sub-Saharan Africa is the most affected region. South Asia has low HIV prevalence in percentage terms; however, in absolute numbers the South Asian subcontinent has the second highest number of young people living with HIV.

In the worst-affected regions, clearly more young females than young males are infected, for biological and socioeconomic reasons.

In the other regions, more young males than young females are infected, because the transmission of HIV takes place among high-risk groups, such as injecting drug users and men who have sex with men (refer to the exercise and discussion on the first day).

While we are observing encouraging declines in several countries in Sub-Saharan Africa, regions that were initially least affected, such as the Eastern European countries, are now showing the most rapid increase in HIV infections.

Slide 6 Why are the goals important?

Global goals are important because they help us to focus on desired health and development outcomes for which there is already a substantial political commitment.

This political commitment in some cases is backed up with funds (for example the Global Fund to Fight AIDS, TB and Malaria).

3.1.3 Discussion and wrap up

25 MIN

Materials

Flipchart 18 *Discussion questions for 3.1.3*

Steps

a. Show Flipchart 18 *Discussion questions for 3.1.3.*

FLIPCHART 18 Discussion questions for 3.1.3

1. *Have any international goals moved the agenda for young people in your country?*

2. *If yes, which goals? How?*

3. *How are these international goals perceived in your country?*

4. *Does your country have any national goals in relation to young people? If yes, what are they? If not, why not?*

b. Ask participants to work with their neighbours in groups of three persons per buzz group.

c. Give the groups 10 minutes to discuss their responses to the above questions.

d. Facilitate a discussion, starting with question 1. Keep the discussion focused.

e. Ask if there was disagreement among people in the groups. If yes, why did they disagree? Ensure that all participants have an equal opportunity to participate. If needed, call on participants or groups and ask them to respond to follow-up questions, such as “Do you agree?”, “How do you feel about that?”, “What would you add?”, “Is the situation the same in your country or state?”

f. Make a list of key points on the flipchart during the discussion.

g. Summarize the main points or lessons learned from both the presentation and the discussion.

h. Ask if there are any other questions to consider.

i. Thank the participants.

Session 3.2 Strategic framework for programming

Agenda for global goals and targets	
00:05	3.2.1 Introduction
00:20	3.2.2 Presentation of the strategic framework for programming
00:10	3.2.3 Introduction to group work
00:30	3.2.4 Group work
00:40	3.2.5 Report back and wrap up (10 minutes per group)
01:45	

Session objectives

By the end of this session participants will be able to:

- List key health and development needs of young people and the common settings through which those needs can be met;
- Explore how various settings could be better used to meet the needs of adolescents;
- Identify areas of strength and weakness in existing adolescent health and development programmes.

Preparation

Presentation

3.2.2 *Setting the scene: a strategic framework for programming*

Flipchart

Flipchart 19 *Framework for programming for young people*

Handout

Instructions for group work: session 3.2.4

Break

Break for refreshments before the group work

3.2.1 Introduction

Materials

Handout: *Five-day agenda*

Steps

a. Go through the session objectives with the participants using their handout.

b. Explain the activities planned for the session and the time allotted for each.

c. Ask if the participants have any questions.

3.2.2 Presentation of the strategic framework for programming

20 MIN

Materials

Presentation: 3.2.2 *Setting the scene: a strategic framework for programming*

Steps

a. Show presentation and go through talking points.

b. Give further explanations and examples in order to overcome misunderstandings.

Note to facilitator

There will be a 30-minute morning break at the end of this presentation.

Talking points

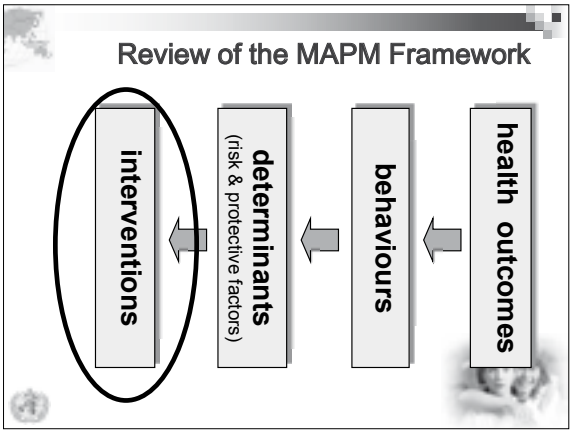
Questions

- What frameworks or approaches do you currently use to organize your thinking about programming for health and development?
- What are some typical programme activities (or interventions)?
- What needs – in terms of the needs of adolescents – are they trying to address?

Slide 1 Review of the MAPM framework

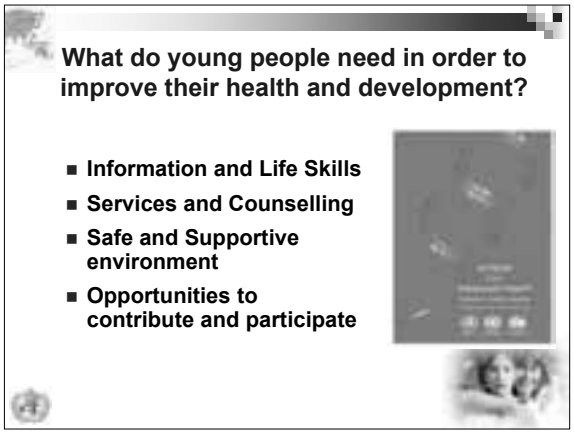
Yesterday we explored the MAPM framework as a "road map" for identifying actions that are most likely to affect the desired health outcomes. These actions are typically called *interventions.*

Once desired health outcomes are identified, along with their associated behaviours and underlying determinants, we can then use different strategic frameworks to help us design our key interventions.



Slide 2 What do young people need in order to improve their health and development?

These key needs are described in a document called *Action for adolescent health: towards a common agenda,* which was published by WHO, the United Nations Population Fund (UNFPA) and UNICEF in 1997.



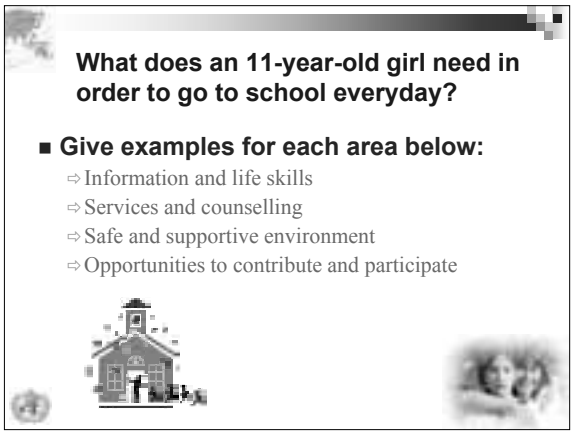
Slide 3 What does an 11-year-old girl need in order to go to school every day?

Question

- Using the list from the previous slide as our framework, what are some of the things that a young girl needs in order to go to school every day?

Write the responses on a flipchart or writing board.

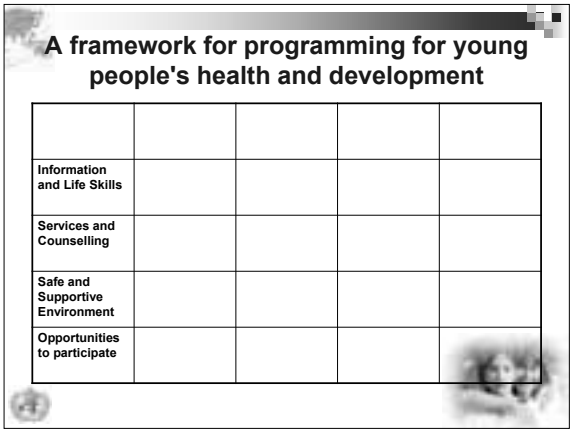
Possible responses include:



- "Know where the school is located."
- "Know how to cross the road safely, where to look, when to cross and when not."
- "Have no holes in the sidewalks, traffic lights that work, a pedestrian crossing available and adult drivers punished if they do not respect the rules."
- "If she falls along the road, she needs services to help her and if she need access to health services, a way to get there."
- "She needs health services that can take care of her."

Slide 4 A framework for programming for young people's health and development

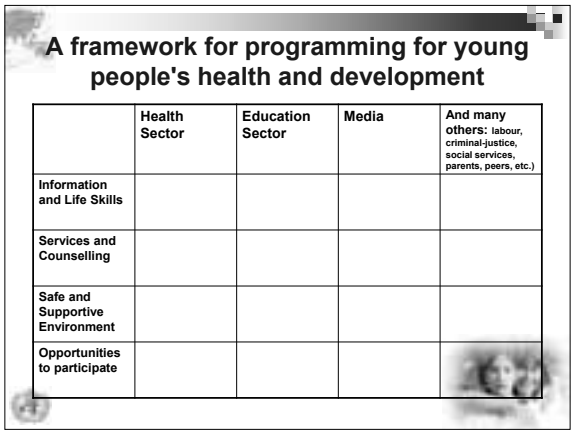
To assess to what extent these needs are being met, we can list the needs in the left-hand column of a table.



Slide 5 A framework for programming for young people's health and development

In the top row of the table we list the settings in which these needs can be met.

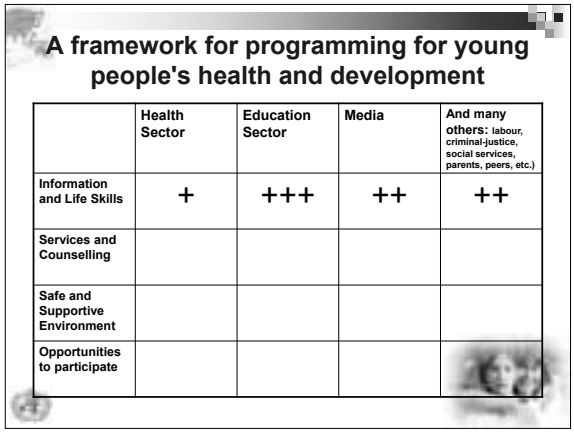
The main settings include the health sector, the education sector, the media and other settings (such as the labour sector, criminal justice sector, social services, parents or peers).



Slide 6 A framework for programming for young people's health and development

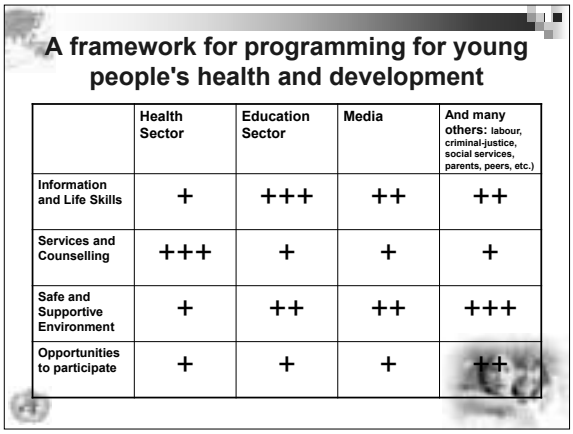
Some sectors contribute more than others towards the needs of young people. The plus signs which we assign here are an indication of the extent that we think the different sectors contribute to ensuring that adolescents have the information and skills they need.

For example, on information and life skills, the education and media sectors contribute a great deal, and the health sector somewhat less – mainly when the adolescent is in contact with health services.



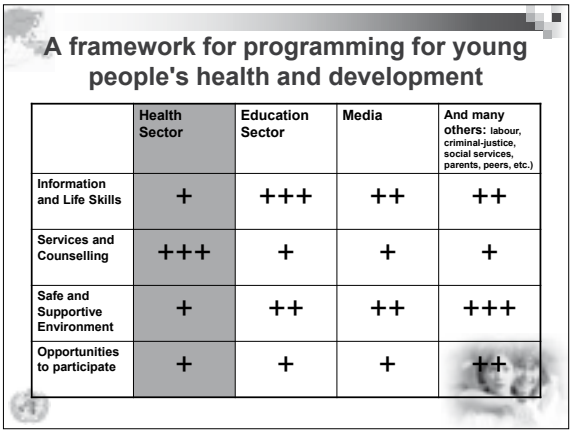
Slide 7 A framework for programming for young people's health and development

If we tried to fill out the whole framework it may look like this (of course, each situation in a country will be different and an individual's assessment of the situation may be different).



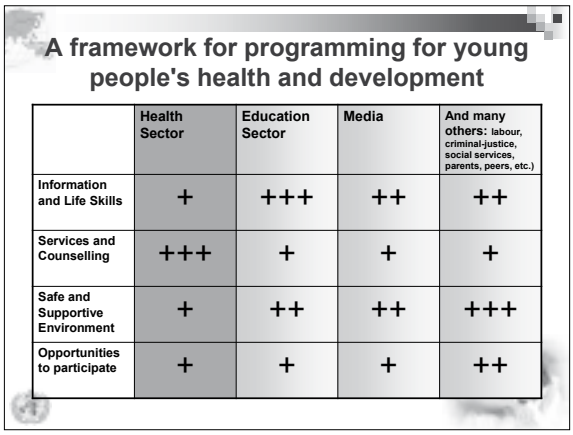
Slide 8 A framework for programming for young people's health and development

WHO works in particular with the health sector and the interventions within this sector. The red column indicates programming for adolescents from a health sector perspective. We will focus on interventions the health sector can deliver and the roles it has to play.



Slide 9 A framework for programming for young people's health and development

But this does not mean we will not discuss the other sectors at all. It is important that all the sectors collaborate to ensure that the best use of resources is achieved and that consistent and equitable services are available. We will consider the work of the other sectors as well, as indicated here by the red shading.



There will be a 30 minute morning break here.

3.2.3 Introduction to group work

10 MIN

Materials

- Handout: *Instructions for group work: session 3.2.4*
- Flipchart 19 *Framework for programming for young people*

Steps

a. Divide participants into four groups (1, 2, 3 and 4).

b. Divide participants by country, state or district. Those from the same geographical area should work together.

c. Read out the names of the participants for each group, including one facilitator for each group.

d. Distribute to each group a copy of the *Instructions for group work: session 3.2.4*.

e. Tell the participants where each group will be working.

f. Ask the participants to quickly move to their groups.

Instructions for group work: session 3.2.3

Participants will be divided into four groups, as follows:

Groups 1 and 2

Outcome: *To decrease rates of smoking among young people*

Groups 3 and 4

Outcome: *To decrease rates of anaemia among young people*

Each group should select a chairperson and a rapporteur.

Each group should fill out its column on this handout using two different coloured marker pens: one colour (red) for what is being done, another colour (blue) for what should be done.

Use the rating scale: ( ) nothing, (+) very little, (++) moderate, (+++) a lot.

	To decrease the rate of smoking among young people		To decrease rates of anaemia among young people	
	Group 1	Group 2	Group 3	Group 4
Information and life skills				
Services and counselling				
Safe and supportive environment				
Opportunities to participate				

Identify the main differences between what *is being done* and what *should be done*

What do you think are the reasons for these differences?

g. Ask if there are any questions.

h. Ask participants to start their work by appointing a chairperson and rapporteur.

i. Remind participants that they have 30 minutes to complete the group work.

3.2.4 Group work

Materials

- Handout: *Instructions for group work: session 3.2.4* (one for each group)
- Red and black marker pen for each group

Steps

a. Each group goes to its designated area and selects a chair and a rapporteur.

b. Give the rapporteur of each group a copy of the handout *Instructions for group work: session 3.2.4.* The rapporteur reads the instructions to the group and fills out the group's column on the handout.

c. At least one facilitator should join each group as a participant. The facilitator(s) should speak only when needed to help clarify the task, to help focus the group on the task, or to answer questions.

d. Carefully monitor the progress of the groups as they work.

e. Give suggestions to help the groups focus on the task and to progress.

f. Periodically tell the groups how much time is remaining.

3.2.5 Report back and wrap up

* (10 minutes per group)

Materials

Flipchart 19 *Framework for programming for young people*

Steps

a. Ask the groups to return to their plenary seats.

b. Put up Flipchart 19 *Framework for programming for young people*.

FLIPCHART 19 Framework for programming for young people

	To decrease the rate of smoking among young people		*To decrease rates of anaemia among young people*	
	Group 1	*Group 2*	*Group 3*	*Group 4*
Information and life skills				
Services and counselling				
Safe and supportive environment				
Opportunities to participate				

c. Ask the first rapporteur to report back on the work of his or her group, using the rating scale for each row: ( ) nothing, (+) very little. (++) moderate, (+++) a lot.

d. Ask the rapporteur to report back on the main differences between what *is being done* and what *should be done*. What did the group think were the reasons for these differences?

e. Repeat the steps above for the second, third and fourth groups.

f. Summarize the lessons learnt.

g. Include in the wrap-up:

- This framework helps us to understand the big picture of where actions need to be taken to meet the health and development needs of young people.
- In the following sessions we will focus on the critical role of the health sector.

Session 3.3 The role of the health sector

Agenda for the role of the health sector	
00:05	3.3.1 Introduction
00:15	3.3.2 Presentation on the role of the health sector
00:20	3.3.3 Discussion and wrap up
00:40	

Session objectives

By the end of this session participants will be able to:

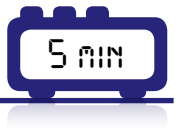
- Discuss the ways that the health sector can contribute to meeting the health and development needs of adolescents.

Preparation

Presentation

3.3.2 *Defining priorities for action: the role of the health sector*

3.3.1 Introduction



Materials

Handout: *Five-day agenda*

Steps

a. Go through the session objectives with the participants using their handout.

b. Explain the activities planned for the session and the time allotted for each.

c. Ask if the participants have any questions.

3.3.2 Presentation on the role of the health sector

Materials

Presentation: 3.3.2: *Defining priorities for action: the role of the health sector*

Steps

a. Show slides and go through talking points of the presentation *Defining priorities for action: the role of the health sector.*

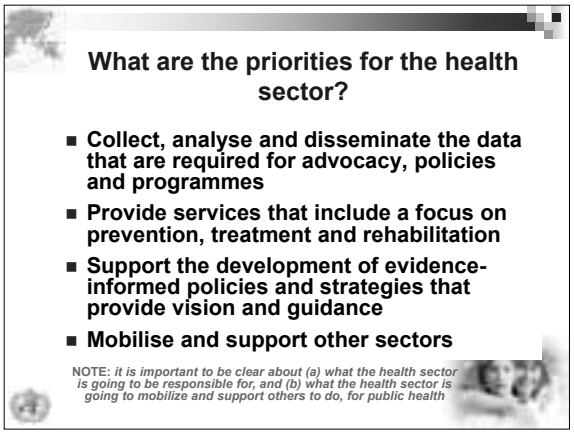
b. Give further explanations and examples in order to overcome misunderstandings.

Talking points

Slide 1 Defining priorities for action: the role of the health sector

Slide 2 What are the priorities for the health sector?

If we focus on the health sector as the main avenue or setting for meeting the information, services, safe and supportive environment and participatory needs of young people, then we must take into consideration the health sector priorities, which are …



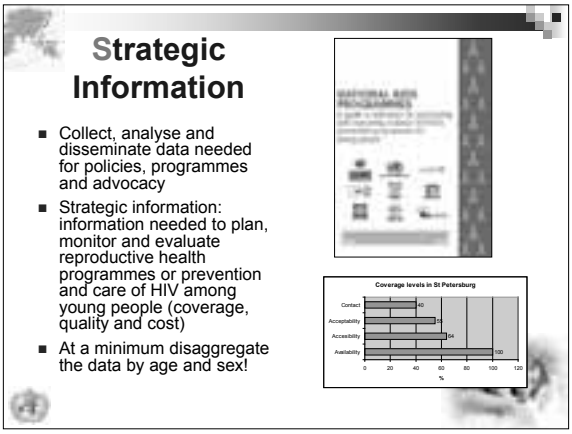
Slide 3 The health sector contribution

These priorities can be summarized as the *4 "S" strategic approach*, which describes the special contribution of the health sector to young people's health and development.

These 4Ss are … (read out slide).

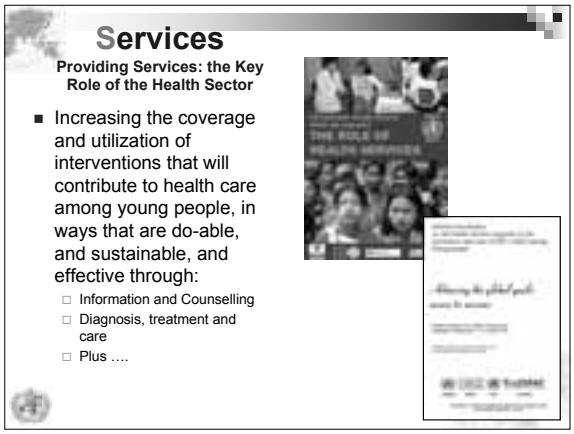
Slide 4 Strategic information

Strategic information is the kind of information that is needed to plan, monitor and evaluate programmes.



Slide 5 Services

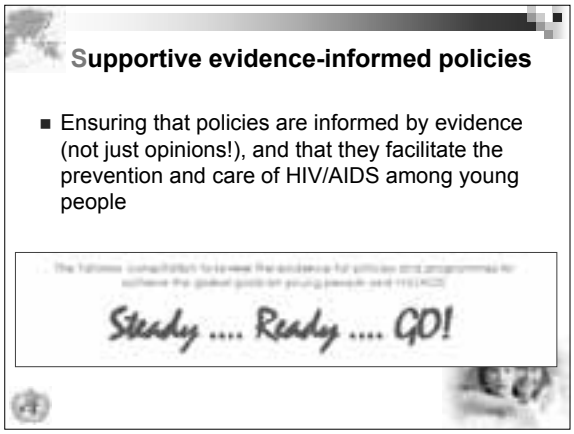
Providing a service is the key role of the health sector – this is something no other sector will do. This is about strengthening health service delivery in a way that improves appropriate use of effective interventions by adolescents.



Slide 6 Supportive evidence-informed policies

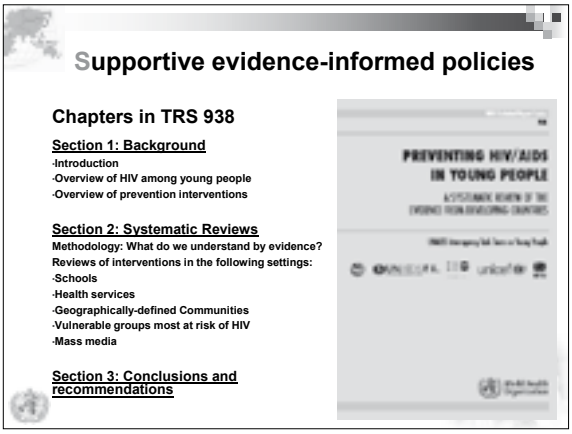
Policies can be important tools to ensure prevention and care are provided. We have to ensure that policies are supportive of what adolescents need to stay healthy. Their effectiveness is determined partly by the effectiveness of the interventions or the approaches they promote. Therefore we have to base these policies as much as possible on evidence.

One of WHO's roles is to produce guidance on effective interventions. An example of such evidence is the Steady, Ready, GO! *Review on HIV prevention for young people.*



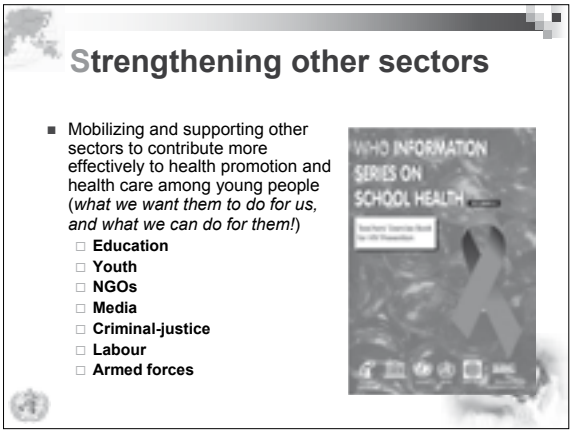
Slide 7 Supportive evidence-informed policies

WHO published a technical report on *Preventing HIV/AIDS in young people*. This document (as you can see here) includes systematic reviews on the effectiveness of interventions delivered in various settings, such as schools and health facilities.



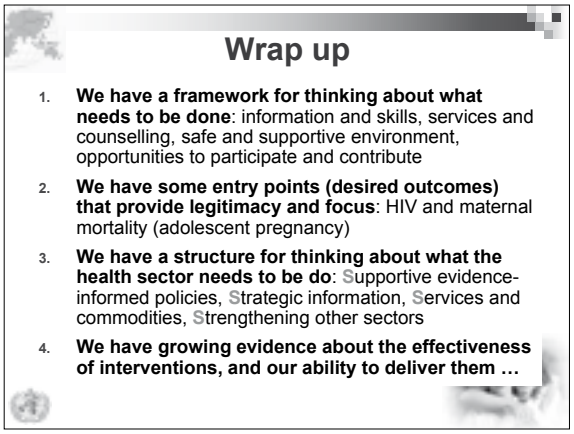
Slide 8 Strengthening other sectors

Finally, an important role of the health sector is to carry out advocacy with other sectors to ensure that they develop interventions for adolescents.



Slide 9 Wrap up

Read out the points: On point 4 you can say that this evidence will be presented or referred to during this workshop.



3.3.3 Discussion and wrap up

20 MIN

Steps

a. Ask participants: Do you understand this framework?

b. Discuss. Then ask: Do you agree with the key functions of the health sector?

c. Lead a brief discussion.

d. Summarize the main points or lessons learnt from both the presentation and the discussion.

e. Ask if there are any questions.

f. Thank the participants.

Session 3.4 Strategic information

Agenda for strategic information	
00:05	3.4.1 Introduction
00:25	3.4.2 Interactive presentation on strategic information
00:60	Lunch break
00:25	3.4.2 (continued)
00:25	3.4.3 Discussion and wrap up
01:20	

Session objectives

By the end of this session participants will be able to:

- Define the term “strategic information”;
- Describe the types of information that are needed to develop and implement HIV and reproductive health programmes for young people;
- Identify information gaps in the participants’ own countries, states and districts;
- Explore key challenges in collecting strategic information and how to overcome them.

Preparation

Presentation

3.4.2 *Strategic information*

Flipchart

Flipchart 20 *Discussion question 3.4.3*

3.4.1 Introduction

5 MIN

Materials

Handout: *Five-day agenda*

Steps

a. Go through the session objectives with the participants using their handout.

b. Explain the activities planned for the session and the time allotted for each activity.

c. Ask if the participants have any questions.

3.4.2 Interactive presentation on strategic information

50 MIN

Materials

- Presentation: 3.4.2 *Strategic information*
- VIPP cards with the headings “interventions”, “determinants”, “behaviours”, and “outcomes”

Steps

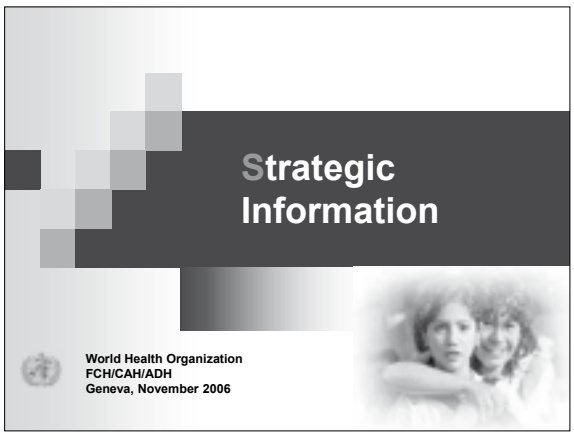
a. Present the slides entitled *Strategic information*.

b. Stop where indicated to conduct buzz group exercises.

c. Give further explanations and examples when needed.

Talking points

Slide 1 Strategic information

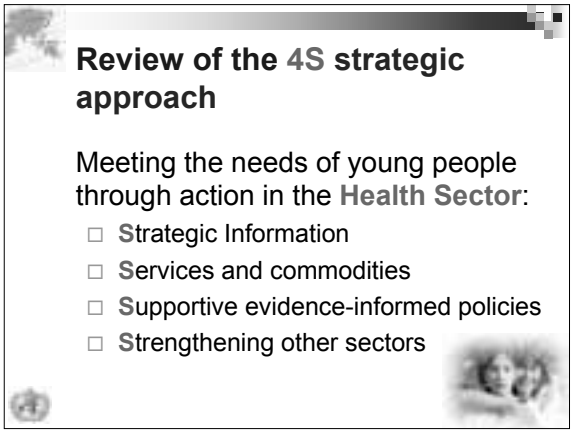


Slide 2 Review of the 4S strategic approach

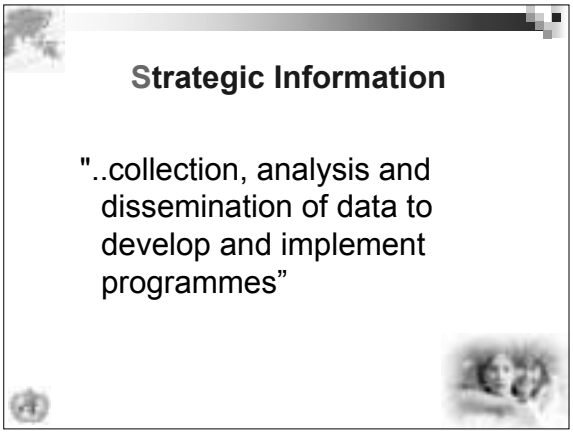
We already discussed the health sector contributions for meeting the needs of young people, and categorized these into four areas (the 4S approach).

Question

So what is strategic information?

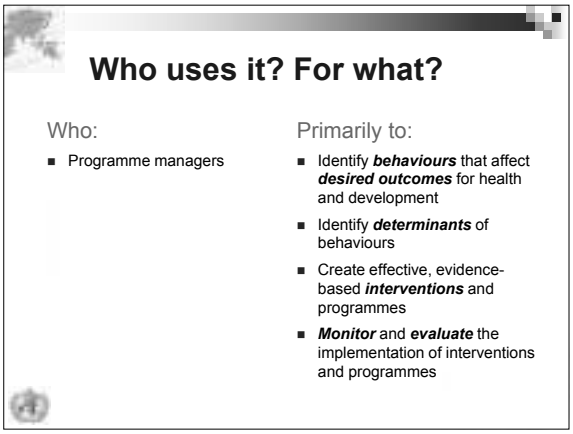


Slide 3 Strategic information



Slide 4 Who uses it? For what?

Strategic information is needed primarily by programme managers to develop, manage, monitor and evaluate interventions and programmes.



Slide 5 Strategic information can also be used to develop, for example …

The main secondary uses are to develop:

- **Policies.** Data are needed for good, evidence-informed policies. Policies are needed to ensure that good data are made available.
- **Advocacy messages.** Other messages targeted at adolescents or others in their environment, such as parents and health services providers.

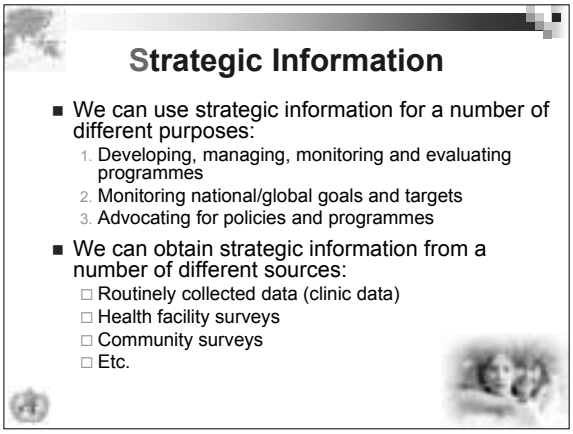
Slide 6 Strategic information

We can use strategic information for a number of different purposes.

(Read out slide.)

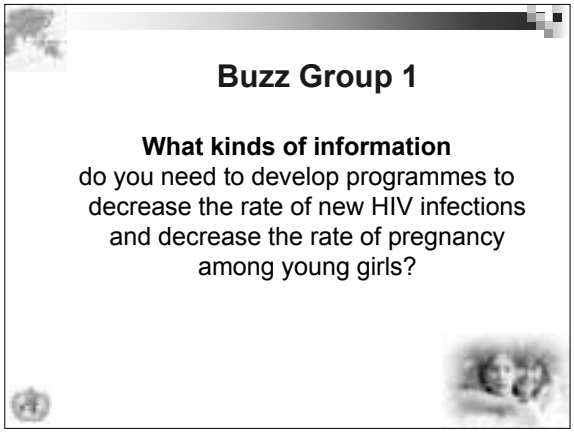
Sources of available strategic information vary from place to place.

(Read out slide.)



Slide 7 Buzz group 1

Ask the participants to work in pairs for 10 minutes to respond to the question on the slide.



d. Ask the pairs to write their responses on VIPP cards (three to five cards per group).

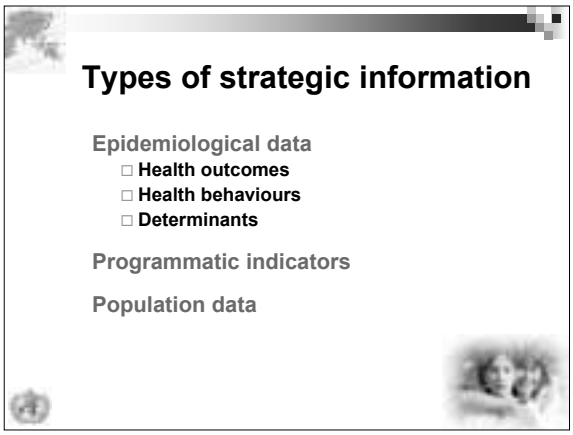
e. Remind the groups to *think in terms of the MAPM framework.* Hang the VIPP cards with the MAPM headings on the wall: "interventions", "determinants", "behaviours", and "outcomes".

f. After 10 minutes, ask each group to hang their responses on the wall under the appropriate headings. Read out the responses and group them under the appropriate MAPM categories. If some cards do *not* fit into any of the categories, discuss why.

Note for facilitator: break for lunch here.

Slide 8 Types of strategic information

There are different types of strategic information that come from different sources.



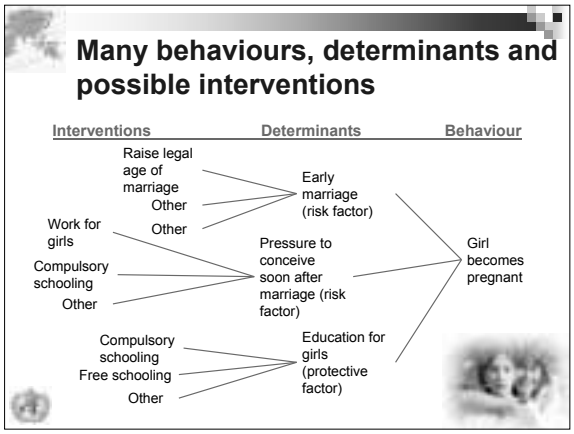
Slide 9 Many behaviours, determinants and possible interventions

This slide shows the complexity of the issues, using early pregnancy as an example.

(Go through slide contents.)

There is often a lot of data and information to deal with on each issue.

Health managers need to look at the data and then set priorities based on the most promising interventions, in consideration of the available resources.



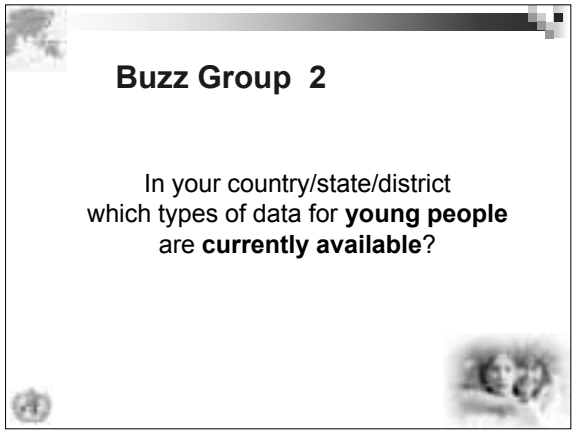
Slide 10 Buzz group 2

Ask the participants to work in groups of three people for 10 minutes to respond to the question on the slide, "In your country/state/district what types of data for young people are currently available?"

Ask each group to report their responses.

As each group reports, regroup the VIPP cards from the previous discussion within the MAPM framework as follows:

- cards describing data that are regularly available at the top;
- cards describing data that are less available at the bottom;
- cards describing data that are *not* available to the side of the MAPM framework.



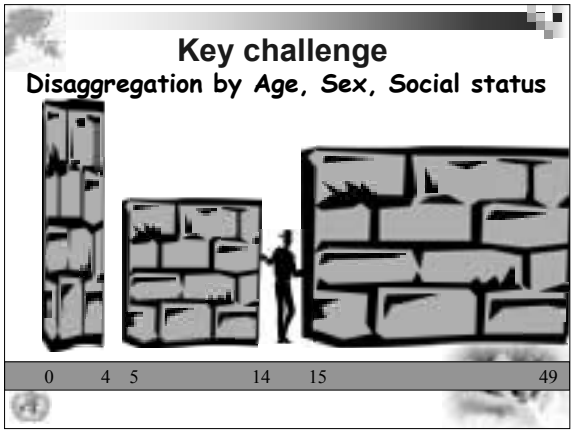
Slide 11 Key challenge

One of the key challenges is to get a true picture of the data related specifically to young people.

Data are usually grouped by ages 15 to 49 and the situation for young people is lost in the adult data.

As we know, the health issues and concerns of a 19-year-old woman are different to those of a woman of 30 years.

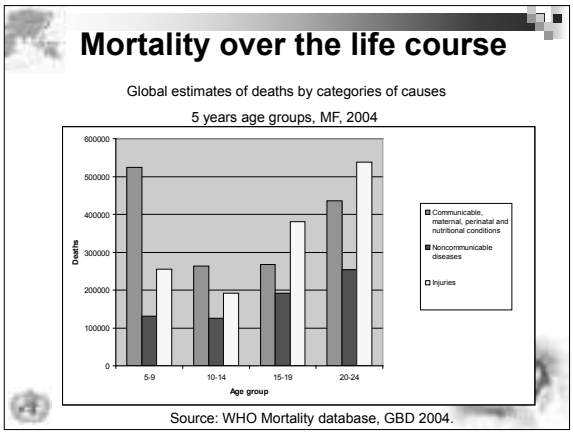
It is important that whenever possible data are collected on age, sex and social determinants because this information can help identify health priorities, as the following slides will show.



Slide 12 Mortality over the life course

When the data are shown in 5-year age groups, it is possible to identify which conditions cause most deaths in each age group.

However, in this graph the male and female data are combined and are not divided by sex. This means the graph hides the higher rate of death by injuries among young men, missing an opportunity to target injury prevention programmes for young men.



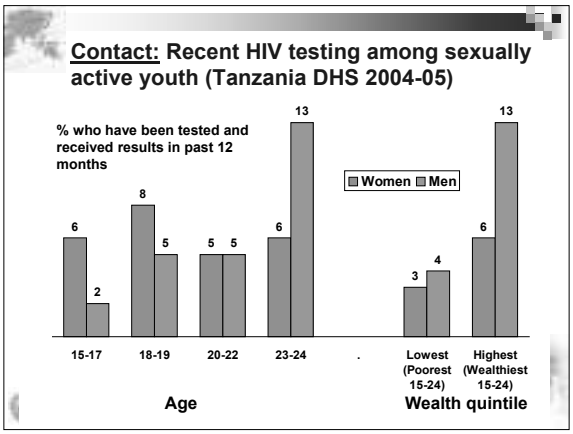
Slide 13 Contact: Recent HIV testing among sexually active youths (Tanzania DHS 2004–05)

Here, the first bar chart shows who has been tested for HIV and received the results in the last year.

The second bar chart tells us that wealthier young men are more likely to be tested for HIV and receive their test result.

Question

How could the data from this second bar chart be used in planning programmes?



Possible responses: free HIV testing, find out the reasons for the low number of women being tested, encourage more young women to be tested and return for results.

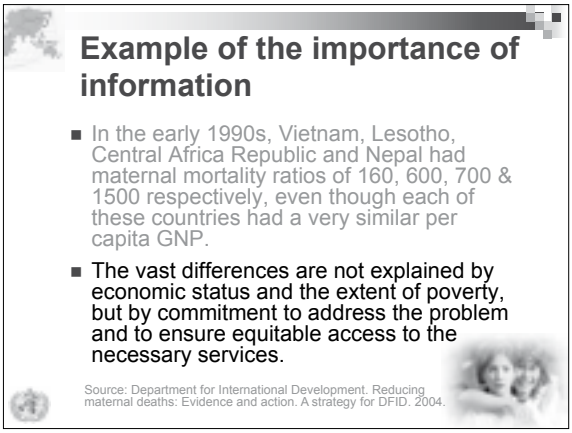
Slide 14 Example of the importance of information

Sometimes it is important to have other information to assist in interpreting data.

(Read out the slide.)

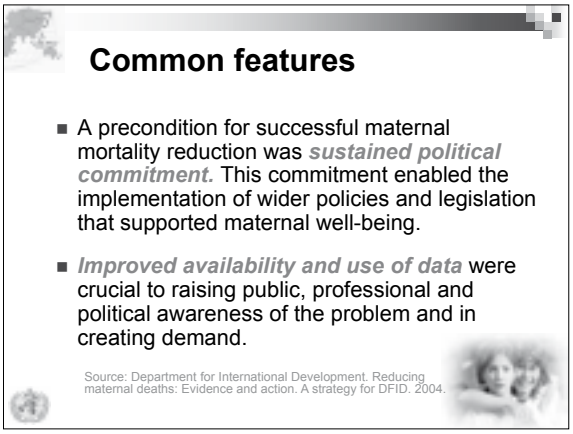
The countries with lower maternal mortality ratios all had:

- a high level of skilled attendance at birth;
- care and transport to care either provided free or covered by an insurance scheme;
- access to curative clinical care.



Slide 15 Common features

Although this example shows the bias towards advocacy and policy rather than data for programming, health managers need to remember these important features for the success of programmes.



3.4.3 Discussion and wrap up

25 MIN

Materials

Flipchart 20 *Discussion question 3.4.3*

Steps

a. Show the flipchart on experiences with disaggregated data.

FLIPCHART 20 Discussion question 3.4.3

Experiences with disaggregated data:

- *What is your experience with disaggregated data by age and sex?*
- *How easy is it to get?*
- *What are the key barriers?*

b. Ask a volunteer to read out the main points for discussion.

c. Lead a brief discussion based on the questions on the flipchart.

d. Encourage all participants to respond. Ask individual participants follow-up questions such as: “Do you agree?”, “What would you add?”, “How is the situation different in your country or state?”

e. If the role of policies was not well discussed during the session, ask: *“Yesterday we discussed supportive evidence-informed policies. Is there a role for policies in making needed data available? If yes, what is it?”*

f. Try to overcome any important difficulties, misunderstandings or negative attitudes.

g. Summarize the presentation and discussions.

h. Ask if there are any questions.

i. Thank the participants.

Session 3.5 Strategic information for programme monitoring and evaluation

Agenda for strategic information for programme monitoring and evaluation	
00:05	3.5.1 Introduction
00:20	Participants’ presentation time (optional)
00:15	3.5.2 Presentation on measuring interventions
00:20	Participants’ presentation time (optional)
00:10	3.5.3 Introduction to group work
00:30	3.5.4 Group work
00:30	3.5.5 Report back and wrap up (5 minutes per group)
02:10	

Session objectives

By the end of this session participants will be able to:

- Describe how the MAPM framework can be used to structure the monitoring and evaluation of programmes;
- List different tools that can be used to measure programming for young people;
- Identify relevant indicators for monitoring and evaluating HIV and reproductive health programmes for young people.

Preparation

Presentation

3.5.2 *Measuring interventions*

Handout

Instructions for group work: session 3.5.4

Other materials

- Handout (at least two copies for each group): *National AIDS programmes: a guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people*
- Handout: example *Global School-based Student Health Survey (GSHS) tool*

3.5.1 Introduction

Materials

Handout: *Five-day agenda*

Steps

a. Go through the session objectives with the participants using their handout.

b. Explain the activities planned for the session and the time allotted for each.

c. Ask if the participants have any questions.

Participants' presentation time (optional)

If you planned a presentation from a participant at this point, introduce it, clearly make the link between the presentation and the theme of this session and reiterate the maximum time duration to the presenter.

3.5.2 Presentation on measuring interventions

Materials

- Presentation: 3.5.2 *Measuring interventions*
- Handout (at least two copies for each group): *National AIDS programmes: a guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people*
- Handout: example *Global School-based Student Health Survey (GSHS) tool*

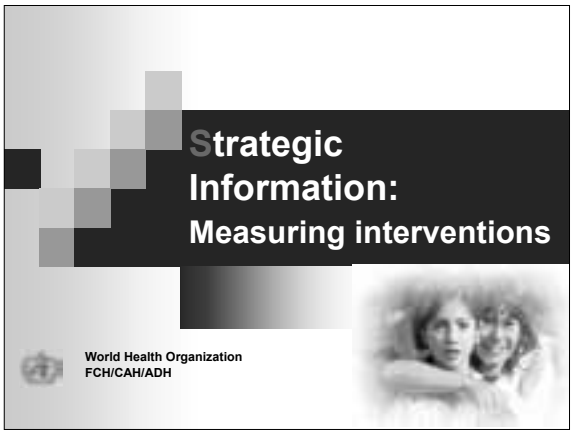
Steps

a. Present the slides.

b. Give further explanations and examples where appropriate.

Talking points

Slide 1 Strategic information: measuring interventions

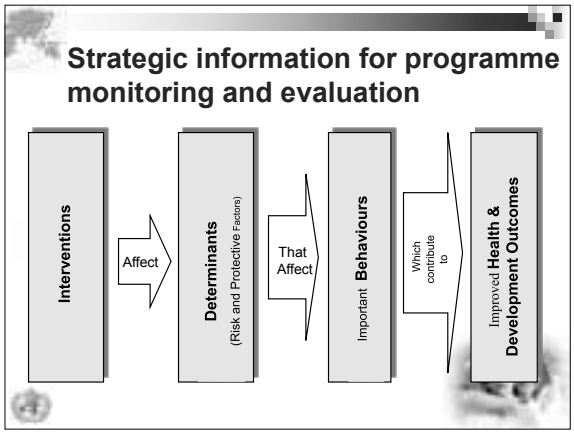


Slide 2 Strategic information for programme monitoring and evaluation

The four steps of MAPM define the pathway or map through which intervention activities can ultimately produce changes in health or development outcomes.

MAPM also provides options for reviewing results at each step of the way.

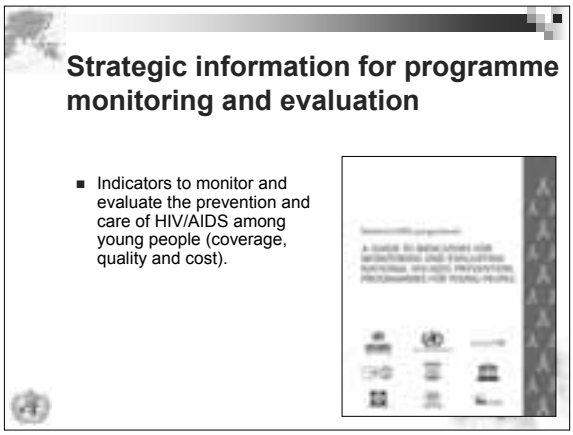
It is not necessary, nor prudent, to wait for the health outcome to be achieved before starting to measure progress.



Slide 3 Strategic information for programme monitoring and evaluation

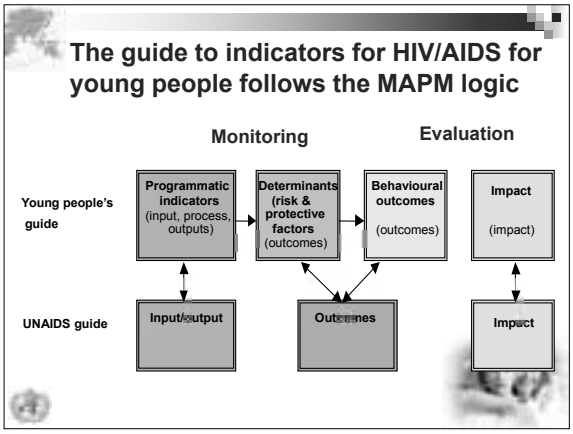
This is an example of a WHO publication that identifies the necessary strategic information for programme monitoring and evaluation for the prevention and care of HIV among young people.

We will use this document in group work today.



Slide 4 The guide to indicators for HIV programmes for young people follows the MAPM logic

Both the WHO document and the UNAIDS guide use MAPM logic. This slide shows how the MAPM terminology is related to another widely used generic monitoring and evaluation framework on indicators – the input/output, outcomes and impact model.

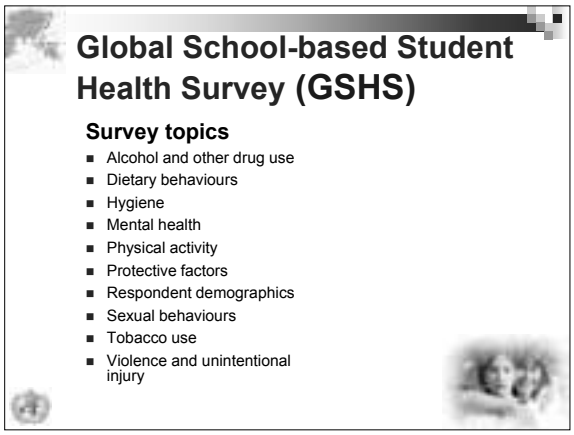


Slide 5 Global School-based Student Health Survey (GSHS)

The Global School-based Student Health Survey (GSHS) is a collaborative surveillance project designed to help countries measure and assess the behavioural risk factors and protective factors in these 10 key areas among young people aged 13 to 15.

The GSHS uses a self-administered questionnaire to obtain data on the leading causes of morbidity and mortality among children and adults worldwide.

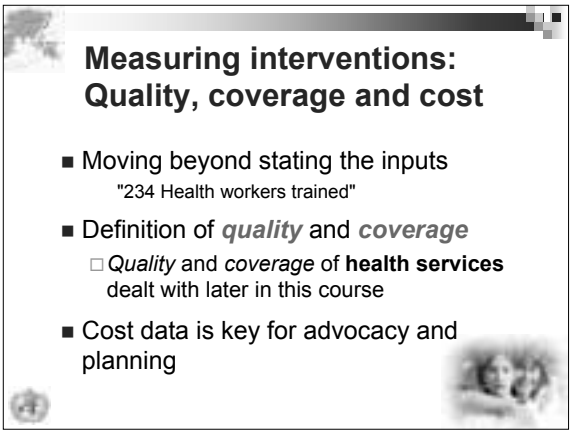
The survey has been implemented in over 100 countries in all regions of the world.



Slide 6 Measuring interventions: quality, coverage and cost

When we are measuring interventions we need to look at quality, coverage and cost.

(Read out the slide.)

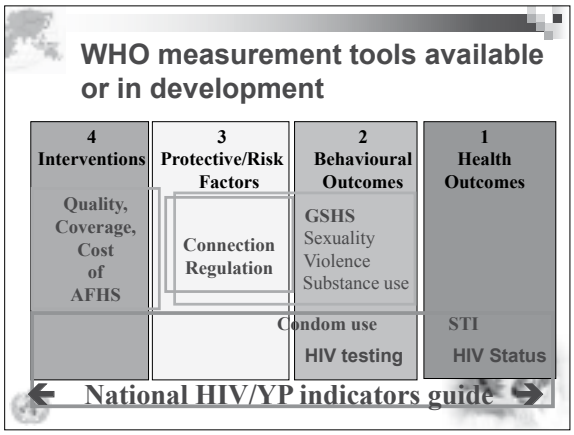


Slide 7 WHO measurement tools available or in development

The **HIV indicators** – key indicators for national programmes on HIV and young people – spans the four columns.

The **GSHS** is a self-reported survey by WHO and the United States Centers for Disease Control and Prevention (CDC) that focuses on health behaviours, and includes some health outcomes and protective factors.

Connection and regulation. The WHO Department of Child and Adolescent Health and Development (CAH) is also developing survey tools on these protective factors.



Quality, coverage and cost of adolescent-friendly health services. WHO/CAH has developed survey tools for quality and coverage of health services and has a draft costing tool.

Participants' presentation time (optional)

20 MIN

3.5.3 Introduction to group work

10 MIN

Note to facilitator

Instead of reviewing the national HIV plan in this group work as stated below, participants could go back to their previous planning groups and work on their own plan, if this is relevant and feasible.

The facilitator should decide beforehand which plan will be reviewed during this session.

Materials

- Handout: *Instructions for group work: session 3.5.4*
- Handout (at least two copies for each group): *National AIDS programmes: a guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people*

Steps

a. Distribute the handout *Instructions for group work: session 3.5.4*. Read out with the participants. Ask if there are any questions.

Instructions for group work: session 3.5.4

Participants will be divided into three groups to review the national HIV/AIDS plans.

or

Participants will return to their previous planning groups to look at their own plans.

Each group should select one person to chair, and another to be rapporteur.

Each group should record the group's responses on flipchart paper.

Refer to the indicator guide for HIV/AIDS and young people, and answer the following questions with regard to the plan:

1. *Which indicators are currently included in the plan?*
2. *What are the proposed sources of data and what are the implications for your work?*
3. *Which indicators in the guide could inform reproductive health programming as much as HIV/AIDS programming?*

Each group should record the group's responses on a flipchart.

b. Hand out copies (at least two per group) of the *National AIDS programmes: a guide to indicators for monitoring and evaluating national HIV/AIDS prevention programmes for young people*.

c. Ask if there are any questions.

d. Ask the participants to quickly move to their groups and start working.

e. Remind them that they have 30 minutes to complete the group work.

3.5.4 Group work

Materials

Handout: *Instructions for group work: session 3.5.4*

Steps

a. At least one facilitator should join each group as a participant. The facilitator(s) should speak only when needed to help clarify the task, to help focus the group on the task, or to answer questions.

b. Carefully monitor the progress of the groups as they work.

c. Give suggestions to help the groups focus and progress with the task.

d. Periodically tell the groups how much time is remaining.

3.5.5 Report back and wrap up

30 MIN*

* (5 minutes per group)

Materials

Report back flipcharts

Steps

a. Ask the groups to return to their plenary seats.

b. Ask a volunteer to help you record responses on a flipchart or writing board.

c. Starting with the last question (question 3), ask: "Which indicators in the guide could inform reproductive health programming as much as HIV programming?"

d. Record and discuss the responses.

e. Ask each group to present their responses to questions 1 and 2.

f. When each rapporteur has finished, ask if his or her group would like to add or clarify anything.

g. After all groups have presented, summarize the lessons learnt from this exercise.

h. Thank the participants.

Session 3.6 Day 3 wrap-up

15 MIN

Materials

Flipchart 15: *Personal diary questions*

Steps

a. Ask participants to open the book that they are using as their personal diary.

b. Go through the two points on the flipchart (the same flipchart as for day 1 and 2 wrap-up).

FLIPCHART 15 Personal diary questions

1. *What did you find particularly useful today? List up to three things.*
2. *List three things you would like to do (differently) in your day-to-day work as a result of what you learnt today.*

c. Ask if there are any questions.

d. Ask them to write their responses in their diary.

e. Look at the agenda for day 4 with them to prepare for tomorrow.

f. Thank the participants for their hard work today and say we will begin again at 8.30 tomorrow morning.

Day 3 Handouts:

- *Session 3.2.3* Instructions for group work
- *Session 3.5.4* Instructions for group work

HANDOUT

Session 3.2.3 Instructions for group work

Instructions for group work: session 3.2.3

You will be divided into four groups, as follows:

Groups 1 and 2

Outcome: *To decrease rates of smoking among young people*

Groups 3 and 4

Outcome: *To decrease rates of anaemia among young people*

Each group should select a chairperson and a rapporteur.

Each group should fill out its column on this handout using two different coloured marker pens: one colour (red) for what is being done, another colour (blue) for what should be done.

Use the rating scale: ( ) nothing, (+) very little, (++) moderate, (+++) a lot.

	To decrease the rate of smoking among young people		To decrease rates of anaemia among young people	
	Group 1	Group 2	Group 3	Group 4
Information and life skills				
Services and counselling				
Safe and supportive environment				
Opportunities to participate				

Identify the main differences between what *is being done* and what *should be done*

What do you think are the reasons for these differences?

HANDOUT

Session 3.5.4 Instructions for group work

You have been divided into three groups to review the national HIV/AIDS plans.

or

You have returned to your previous planning groups to look at your own plans.

Each group should select one person to chair, and another to be rapporteur.

Each group should record the group's responses on flipchart paper.

Refer to the indicator guide for HIV/AIDS and young people, and answer the following questions with regard to your existing plan:

1. Which indicators are currently included in the plan?

2. What are the proposed sources of data and what are the implications for your work?

3. Which indicators in the guide could inform reproductive health programming as much as HIV/AIDS programming?

Record your group's responses on a flipchart.

Notes