

Christian Association (WYWCA), the World Association of Girl Guides and Girl Scouts, the World Assembly of Youth, and the International Planned Parenthood Federation (IPPF). In addition, there are a great many smaller NGOs throughout the world which play an important role in meeting adolescent health needs, while professional and scientific bodies such as the International Association for Adolescent Health and the Society for Adolescent Medicine are playing their full part.

Within the United Nations system, adolescent health policy has been stimulated by a series of actions including the 1989 WHO/UNFPA/UNICEF joint statement on the reproductive health of adolescents (204), a series of World Health Assembly and WHO Regional Committee resolutions, and the establishment of a unit in WHO following technical discussions on the health of youth at the 1989 World Health Assembly. In addition, the United Nations Convention on the Rights of the Child (which covers the age range 0–18, and hence includes adolescents up to the age of 18 years), and the Convention on the Elimination of All Forms of Discrimination against Women, are two major global policies with significance for adolescent health, as is the World Programme of Action for Youth to the Year 2000 and Beyond.

Importantly, many governments are now in the process of formulating national policies on adolescent health, and some are beginning to implement national adolescent programmes. Not only is the value of taking action to promote adolescent health being recognized, but so are the multiple and long-term costs of *not* taking action. Slowly but surely, the questions being posed are less often *whether* adolescent health should be given attention, and more commonly *what* needs to be done and *how* best to do it.

As commitment increases, more players are entering the field, and there is now a need for people with sound experience of adolescent health and development to contribute to national-level initiatives. One such initiative has been the establishment in several countries of a national task force on the health of young people, which aims to promote a common understanding of adolescence within the cultural context. Bringing together key people from the many different sectors which influence, and have interests in, adolescent health (including young people themselves) can be a valuable first step. Such an initiative can help create a cooperative, rather than competitive, atmosphere, and draw on expertise from different disciplines and institutions essential to adolescent health. It will help to review the perceived place of adolescents in contemporary conditions and

identify the major present-day health and development (problems and) needs of adolescents.

Achieving a consensus around common goals will also minimize differences about the means to achieve these ends. Many countries are already using this mechanism to plan national adolescent health programming. Malaysia, for example, has established a national task force for the implementation of its plan of action for adolescents to be implemented by the health sector in coordination with other sectors. A national workshop on adolescent comprehensive health was held in Kuala Lumpur to propose the basis for a national plan, discuss the relations and the role of other relevant sectors in adolescent health, and to designate and institute the national task force.

There is now an increasingly urgent need for sound information and technology to improve the understanding of policy-makers on adolescent status, behaviour and relationships, and on the risk and protective factors important in adolescent health and development. Information drawn from the conducting of a situation analysis (see Box 24, section 8), coupled with the major arguments for promoting adolescent health, can provide powerful tools for stimulating policy formulation at national level. Because of the multifaceted nature of adolescent needs, such tools are likely to be most valuable when they are part of a national policy which cuts across the sectors of importance to young people, including health, education, youth, social welfare, labour and justice. This will help to ensure consistency, coherence and a commitment to adolescent health, and help remove legislative barriers which block young people's access to necessary information, education, skills-training and services, especially with regard to reproductive health. Such an approach can lead to the provision of political (and often financial) support to NGOs, which are often in the forefront of adolescent health promotion, and to strengthening different government departments responsible for providing services to adolescents.

The formulation of national policies for adolescent health is clearly a multisectoral process and has implications for the economic and social environment in which young people live. A national policy with strong government commitment also helps to ensure direction, funding and operational support. Formulating national policies has already helped bring about the achievements summarized in Box 22.

An analysis of the implementation of programmes emanating from national adolescent health policies in Brazil and Costa Rica suggests that a number of components are crucial to an effective national adolescent health policy (C. Hanson, unpublished data, 1995):

Box 22**The benefits of formulating national policies on adolescent health**

- Increases availability of programmes — coherent national policy can lead to the mobilization of the financial, administrative, and human resources needed to ensure that activities for promoting and safeguarding adolescent health are widely implemented by public and private organizations.
- Signals government commitment to adolescent health — providing sustainable, effective programmes to young people at the local level requires strong political commitment at the national level to ensure direction, funding and operational support. A political environment truly supportive of adolescent health will lead naturally to beneficial policies and programmes.
- Advocates awareness of adolescent issues and needs — a well documented, active national policy which makes the case for adolescent health can permeate governmental, private, and public levels of society, raising awareness of adolescent issues, identifying problem areas and advocating additional support. This process can be particularly important when dealing with sensitive issues such as sexuality and reproduction.
- Provides an overall framework for action — the introduction of adolescent policy can stimulate changes in multiple sectors. In Brazil, the initial framework was established through the new Constitution and the resulting Statutes on Children and Adolescents. This framework defines the age of adolescence and attaches both rights and obligations to this population group. The Statutes, for example, stipulate that young people have the right to health protection (Title II, Chapter I, Article 7). A subsequent, more specific, policy developed by the Ministry of Health and Ministry of Education (Interministerial order no. 79.996) complimented the Statute policy as it called for the implementation of an educational project within schools, for the prevention of HIV, to enable young people to protect their own health (C. Hanson, unpublished data, 1995).
- Gives an institutionalized focus on adolescents — because it reflects government commitment, policy development ensures that adolescent issues remain an enforceable priority. While it is important that policies be brought onto the books as a point of reference, national programmes are able to go one step further as they institutionalize a focus on adolescents by putting policy into practice. National programmes link policy with the funding sources, administrative responsibilities, and human resources necessary to implement policies. Unlike individual policy, the policy package inherent in a national programme is eligible for a standard budget allotment to secure its implementation and provides opportunities to retain and develop human resources.
- Facilitates increased multisectoral collaboration — the development of national policy for adolescent health provides an opportunity for professionals from various sectors to review, jointly with adolescents, their

Box 22 (continued)

perceived needs and priorities, and to introduce a plan of action which is mutually owned and accepted. Continued collaboration among government agencies and the public and private sectors is critical for the successful implementation of a national programme. In Costa Rica, representatives from various ministries, PAHO, Social Security, and the University of Costa Rica collaborated to assess the status of adolescents in the country and proposed the direction of the national programme. The programme, now part of the Social Security sector, strives to continually solicit input from outside agencies (C. Hanson, unpublished data, 1995).

- Provides the context for political change — national programmes provide a unique point from which to evaluate the availability and impact of activities directed at young people in a country. By reviewing programme objectives, the intended outcome becomes apparent while current policy and health status indicators provide a picture of the present situation. An analysis of the gap between these two scenarios offers a rational context for political change.

- a stable, guaranteed funding source;
- designation of an agency or individual responsible for making the policy operational;
- integration of the policy with other national policy frameworks so as to avoid contradictory policy, and to facilitate action;
- applicability of policies to all adolescents (including those in and out of school, the poor and homeless, and sex workers);
- policy that encourages, but is not dependent upon, intersectoral collaboration;
- a way of ensuring that the resulting programme is sustainable, with provision for evaluation and development.

The responsible agency for many national adolescent health policies in Latin America is the Ministry of Health (as in Brazil, for example). However, in Costa Rica, following a recent merger, the Ministry of Health and the department of social security jointly manage the national programme. In Chile, a key stimulant has been the National Service of Women, an office with the status of a ministry. The Plan for Equal Opportunities for Women includes the objectives of ensuring access by adolescents to health, education, family planning and social services, the integral care of early motherhood and the right to practise healthy sexual behaviour (G. Robinson, unpublished data, 1995a). In Malaysia, an ambitious national youth policy, *Rakan Muda* (C. Serrano, personal communication, 1995), is implemented by the

Ministry of Youth and Sport, and aims to direct the energies of young people into a number of lifestyle programmes that have strong youth appeal, and to develop their will to resist the many current social ills. The fact that after only a year's operation, almost a million young people have enrolled, suggests that *Rakan Muda* may well achieve its ambitious objectives.

A project coordinated through WHO's Programme on Substance Abuse for the prevention of substance abuse among young people is being implemented in seven countries in central and eastern Europe — Bulgaria, the Czech Republic, Estonia, Latvia, Lithuania, Poland and Slovakia — using the strategy of building political commitment at the national level. The key feature of this project is that all seven countries have opted to establish national task forces on substance abuse. Another feature has been the crucial involvement and participation of NGOs and young people in the task forces (L. Riley, personal communication, 1996).

There are many examples of NGOs that have effectively influenced the development of national policies. In Swaziland, the National Youth Council, a government-supported NGO, has proposed a national adolescent health policy with the objectives of "promoting healthy lifestyles among young people with a special focus on the dangers of alcoholism, adolescent pregnancy, AIDS and drug and substance abuse". This policy is now under consideration by the government.

Another example is the Uganda Youth Development Link, an NGO working with street children in Kampala, which has established a community advisory committee consisting of senior local government officials, other NGOs, religious leaders, welfare workers, medical practitioners, journalists, urban authority workers, and street youth. Through its activities, the committee has increased awareness within police, government and humanitarian agencies, and this has led to a fairer treatment of street youth, and increased their access to the services they need (183).

SODIFAG, an NGO in Guatemala City, has been working with children and young people. One of the major accomplishments of the organization was identifying large numbers of youth workers, and overcoming the resistance of employers to activities aimed at improving their working conditions. SODIFAG also succeeded in convincing the government to revise and strengthen its child welfare legislation through collaboration with other NGOs dealing with children's rights (49).

Other bodies, such as professional associations (for example, national medical and nursing societies in countries); affiliates of international NGOs such as IPPF (for example, the national family planning associations in Indonesia); national member associations of international organizations like the World Organization of the Scout Movement, the International Federation of Red Cross and Red Crescent Societies and the WYWCA; and the many religious NGOs (as in most African countries and many countries in Asia) all operate under their own organizational policies which direct their activities relating to adolescent health and other areas. It is likely that these many initiatives together create a groundswell which eventually influences national adolescent health policies.

Despite all the progress, those working to improve adolescent health and well-being continue to come up against the same arguments and contentions that have often served to undermine or even postpone action in this area. What follows is an account of the key obstacles to action which have persisted — often in the face of clear evidence to the contrary — and of some of the ways in which these obstacles can be overcome.

7.2 Adolescents are regarded as healthy

The health of adolescents has been somewhat neglected in the past, perhaps because as a group they are perceived to be relatively disease-free. While this is often the case when one looks at morbidity and mortality statistics¹, behaviour which starts in adolescence frequently leads to health problems which only emerge in later life, at immense cost to the individuals themselves and their societies. In addition, their health problems are often considered to be self-inflicted and deserving of punishment because they are often the result of behaviour that is socially disapproved of. All of this disguises the fact that it is precisely those behaviour patterns established during adolescence that are responsible for some of the major illnesses of adulthood. Promoting and protecting adolescent health is in fact an excellent investment, both in the short term and in the long term. Many kinds of activities that can promote development and prevent health problems are potentially low-cost and high return — this is a compelling argument to which political commitment must be brought.

¹ Although relatively speaking adolescents are as a group "disease-free" this assertion does not hold in the case of STDs (including HIV/AIDS), the levels of which are disproportionately high among young people generally (see Table 2, section 2).

A better understanding of adolescent needs and their potential, along with the principles of effective intervention, disseminated at all levels of society in specific cultures, can have a powerful influence in developing positive action and fulfilling the enormous potential that the health and development of young people represent both for themselves and for the future of their societies.

The promotion of adolescent health and development and the prevention of problems before they occur is not only more humane but also more cost-effective than responding to problems after they occur and attempting curative action when it may be too late. No one would quarrel with the value of immunizing children against disease when that is possible, rather than waiting until the illness occurs to treat it, or overcome its effects afterwards. Yet with adolescence there has been a high degree of reluctance to take preventive action, responding instead to problems after they occur.

Where such negligent attitudes towards the health of young people are compounded by a general lack of appropriate health information and education, young people do not gain an adequate understanding of their own maturation nor acquire the necessary skills to deal with new relationships, and are unaware of existing services which they could use for their health. This prevents them from taking action to help themselves, or use available services.

7.3 Reluctance to confront sensitive issues

Three successive world population conferences — the 1974 World Population Conference in Bucharest, the 1984 International Conference on Population in Mexico City, and the 1994 International Conference on Population and Development in Cairo — have expressed increasing concern about adolescents. In 1984, the conference report recommended that boys and girls be helped to secure adequate education on family life and sex education, and that appropriate family planning information and services be made available to them. The 1994 conference carried the issues of reproductive health, gender equity and adolescents to a new level of world attention. The Programme of Action which resulted called for a substantial reduction in adolescent pregnancies, the provision of counselling and other services to achieve this, and for broader reproductive health concerns such as STDs (including HIV/AIDS) to be addressed.

As outlined in Box 22, a national policy framework supportive of adolescent health can also make the implementation and acceptance of such programmes easier. Explicit policy, however, requires sufficient consensus among opinion leaders and decision-makers. Ideally

policies should be formulated with the involvement of young people themselves and the wider community. This can be a slow process, however, and in reality the order is often reversed with pilot projects or small-scale efforts — documented to demonstrate their value — leading to policy development. There is, therefore, an interplay between policy development and programme efforts. Often the policy mandate can follow years of small-scale or low-key implementation. In Colombia, after a long history of academic study and curricular development, policy mandating sex education in all schools was approved in 1992 (84). Jamaica too experienced years of scattered initiatives (often with NGO involvement) but not until 1994 was policy approved for the systematic provision of sex education courses, which additionally included elements of staff training, curricular development, and evaluation (84).

Time and effort will be needed to understand the views and concerns of young people and adults (from school, religious institutions and other interested community agencies and groups). Several successful programmes have held open discussions with community members before beginning their programmes of action on health education and peer education for reproductive health. Staff were trained to lead such sessions and other participatory methods to build a common understanding with communities and generate support. The sensitive nature of discussing sex and related sex education and reproductive health services calls for attention to effective mechanisms to build support. Haste can alienate the community and limit support and hope for long-term programming efforts.

“Policy development on adolescent reproductive health tends to be in an early stage; for this reason, and because of cultural sensitivities, inadequate procedures and decentralization, translation of these policies into programme plans and actions remains weak. Special efforts are needed to operationalize [adolescent reproductive health] policy” (84).

A further obstacle is the implicit threat felt in many societies that the subject of adolescence is imported, and while there is anxiety about changing conditions, there is also the concern that foreign approaches will alienate their children.

In addition, there are often “knee-jerk” responses by health authorities to highly publicized events which are usually inappropriate and ineffectual. Such responses also tend to be expensive and can, therefore, divert funds from better researched and more effective approaches. The related tendency to employ scare tactics as a public health response to high profile issues appears to be wholly counter-

productive — people's anxiety may increase but they may be unwilling or unable to change their behaviour patterns. Furthermore, if scare tactics are subsequently shown to be ill-founded, then there is an enormous loss in the credibility of the responsible organizations/department, particularly among young people. When credibility is lost, effective action in the future becomes even more difficult.

Some successful programming efforts have developed good working relations with the local media, and have shared information with them on an ongoing basis. In this way they have been able to bring about a more balanced discussion of issues, and coverage of events. This approach helps, even after work has begun, by calling attention to the positive involvement of youth, families, and other groups.

7.4 Investing in young people is seen as a drain on social and economic resources

Rather than being a drain on their communities, young people are an often unacknowledged resource in all societies. They often play vital roles in their families, helping both parents and younger siblings. They generate the enthusiasm, ideals, creativity and aspirations, without which societies would become moribund. Many young people provide the main income for their families by starting work too early in life and in hazardous conditions, others serve their communities through youth organizations and, even among the unfortunately increasing numbers of homeless young, some overcome adversity and make a positive contribution to society.

It has been estimated that some 40% of deaths in developing countries, and 70–80% in developed countries, are attributable to lifestyles (28). Unprotected sex makes adolescents vulnerable to STDs (including HIV/AIDS) and, in the case of girls, to early and unwanted pregnancy and possibly unsafe abortion. The ensuing problems are both health-threatening and life-threatening, and can be psychologically, socially and economically devastating. Sexuality is a universal phenomenon in all young people, and their sexual and reproductive health needs merit special attention, not only because of the need to reduce health risks, but also in the context of loving and responsible relations. The use of tobacco, and abuse of alcohol and other substances will increase the long-term risks of cancers, cardiovascular, and respiratory disease. Alcohol and other substances may also impair judgement and increase the risks of both accidental and intentional injury. Poor diet could lead to overnutrition (whereas inadequate food as well as poor choice of available local foods could lead to undernutrition), and poor oral hygiene to oral disease.

Inadequate exercise will increase the risk of health problems throughout life, while inappropriate exercise can lead to serious injury.

Most problem behaviour, however, can either be avoided or made safer or even beneficial. When sexual relations occur, pregnancy and STD can be prevented; tobacco need not be used; alcohol can be used in moderation; where adequate food is available, a well balanced diet can be eaten; appropriate exercise can be taken. Furthermore, young people can be protected at the workplace; and the knowledge, skills and information they and others need can be provided. While the alleviation of poverty and the adequate provision of schooling must be achieved, much can be learned meanwhile from those who have been able to thrive despite inadequate income and education.

A case must be made for the value of investing in the health and development of the young, including the cost of *not* meeting this need. The enormous public health costs of diseases which become manifest in later life as a result of behaviour begun in adolescence is a powerful argument for investing in adolescent health. Thus policies that result in supporting health-promoting behaviour and reducing damaging behaviour will result in significant savings in the economic costs of illness and death, including the direct costs of health care. There is a need to demonstrate the value and feasibility of action building on existing systems, and having measurable results. This is particularly because of the widely held misconception that nothing can be done without considerable resources, despite initiatives which have shown that this is not the case.

This type of knowledge on the special features of adolescents should be used to promote a greater awareness among policy-makers and politicians. They should be convinced that if problems are not addressed today they could be worse tomorrow. Since adolescent concerns have to compete against other issues, presentation of such concerns must include alternatives and cost-effective measures, with a view to mobilizing the necessary resources to make things happen. One strategy could be to identify and present adolescent issues that could be broached without controversy, and then after gaining an opening to try to seek support for other more sensitive issues.

While young people face many new problems, there are also new opportunities which, if combined with the energy and creativity of young people, can bring tremendous dividends. Recognition of young people as a resource facilitates their participation in the development, implementation and evaluation of programmes (Box 23). One way to draw upon such resources is by involving young people in programmes which are designed to meet their needs (for more detail

Box 23**Giving a voice to young people**

The narrative research method to study sexual behaviour patterns of young people was developed jointly by WHO and its partners, the World Assembly of Youth and the World Organization of the Scout Movement, while using it in eleven African countries to learn about young people's awareness, knowledge, attitudes and behaviour related to their sexual and reproductive health. The project drew upon youth leaders aged 18–25 years, of both sexes, to develop the instruments used to collect information from over 13 000 adolescents, as well as to collect and analyse the data (206, 207).

Situation analysis of street children and street youth in the Philippines, a response to the significant rise in the number of street children (and young people generally) in the Philippines, sought to define their current situation and aspirations and to use the findings to formulate specific programmes and policies. It was carried out by the Kabalikat ng Pamilyang Pilipino Foundation, for UNICEF, in five cities and involved young people aged 7–12 and 13–18 years (209). Young people used participatory approaches such as drawing and drama to gather information. Other methods used consisted of interviews with randomly selected street children and other young people and focus group discussions with young people and service providers. The methodology also included one-day participatory workshops to further define and understand the situation of the respondents. The youth peer educators also arranged the venues for the information collection phase and translated the tools used into the local language.

Young people's involvement in family planning associations concerns a 1995 meeting endorsed by the Europe Regional Council of IPPF, which brought together representatives of young people involved in the activities of such associations in Europe. A preliminary survey of European family planning associations indicated that the majority of them identified young people as the key target for their programmes to promote good sexual and reproductive health. The meeting and resulting strategy document demonstrate how an organization can formally draw upon young people as a resource for the renewal of policy and programme approaches. The meeting recommended:

- IPPF investment in youth involvement through an annual competition offering start-up funding for the most innovative project at family planning association level;
- governance in the associations and IPPF, including training designed to improve the skills of young volunteers so they can play an active role in the governance of the federation;
- youth involvement in the associations through youth groups, networking, cooperation and training/skills development;
- communication between representatives from active family planning association youth groups in order to support information sharing and programmatic support;

Box 23 (continued)

- youth-friendly service provision built around the involvement of young people in planning and management, new staff training, operation and evaluation of projects, and policy of youth employment so as to create a more balanced age profile among staff;
- advocacy at IPPF and associational levels to ensure youth representation on the IPPF Regional Council and the associations' boards, respectively, and to encourage establishment of association youth groups to strengthen lobbying to national governments on legislation and sexual health policy.

see section 8.4). Such a client-centred approach is advantageous to young people themselves as well as the programmes. If young people are encouraged to participate and are rewarded for their contribution, they can:

- acquire knowledge and marketable skills, and avoid problems, all to the benefit of their own personal development;
- help formulate, implement and evaluate policies and programmes that are attuned to their special needs (thereby ensuring that resources are put to the best possible use).

8. Assessing priorities for action

8.1 Background

As interest in adolescent health and development rapidly gains momentum, a host of initiatives intended to improve their situation are being undertaken, often without any systematic assessment of priorities. Given the importance of integrating and coordinating interventions to optimize outcomes for adolescents, it is vital to arrive at a set of priority actions that would guide the programme development and implementation process. The process for priority setting should start with the assessment and analysis of the situation that adolescents face in their environment in order to establish a sound information basis for future action. Undertaking such a situation analysis provides the opportunity for developing partnerships with adolescents from the very beginning of the information collection and programme planning processes. This will help to ensure the relevance, acceptability and long-term effectiveness of the resulting programmes (see also section 6.2).

A situation analysis will also provide a baseline against which to measure change. Relatively rapid methods exist that are tailored to

key issues of adolescent health, often involving young people in the data collection process. Gaps in needed information will certainly be identified considering what is currently collected and how it is reported.

The identification of priorities will be linked to the guiding concepts specific to adolescent health. Discussion or clarification of a set of guiding concepts may therefore be another important initial step in the national planning of programming priorities. There is need to determine whether the guiding concepts which underlie the goal of investing in young people's long-term development (see section 3) differ from those which underlie programmatic responses to problems that result in illness and injury among the young. Thus, a belief in the benefits of supporting the overall development of young people will influence decisions on resource allocation. Finally, different viewpoints based upon religious or cultural beliefs could influence the perception of the situation and approaches to dealing with it.

Situation assessment and analysis should, therefore, seek information on adolescent health status and behaviour — both with positive and negative implications on health and development — as well as on the social and political factors influencing such behaviour, since the context in which young people live is not only rapidly changing, but is also specific to their societies. The current sectoral responses provided for adolescents in a variety of settings (including the provision of opportunities and support for adolescent growth and development) will also provide valuable information. Additional information on the availability and usage of activities in the areas of health care, education, social support, recreation, and vocational training offers a picture of both the potential opportunities for young people and a profile of those reached. Understanding the capacity of the various settings to provide interventions and related training is key to identifying needs for technical assistance and locating technical resources. Analysis of laws and policies relating to all areas of adolescent life is also vital to improved understanding of factors in the environment that encourage or hinder adolescent health and development.

Unfortunately, reference to adolescent health status and behaviours it is almost always focused on the negative and problematic and not on the positive aspects of resiliency and coping strategies. Keeping this bias in mind, the available information on adolescent health problems shows that they are not evenly distributed, and are certainly exacerbated by gender inequities, homelessness, war and natural disasters. Thus, the prevalence of violence, suicide, accidents, unwanted pregnancies, HIV/AIDS, other communicable diseases, and the use

of tobacco, alcohol and other drugs varies from country to country. Furthermore, the health status of adolescents, and the degree to which they are at risk in each country, is likely to differ by sex, age, school attendance, rural and urban residence, ethnic differences and economic status.

The settings in which to seek information include, for example, the home, the school, and the health centre. Within each of these settings are the key people who influence adolescent behaviour and/or deliver interventions to promote young people's health (see section 4). These include parents, teachers, health care providers etc. The kinds of information that these key people can provide make them very important allies.

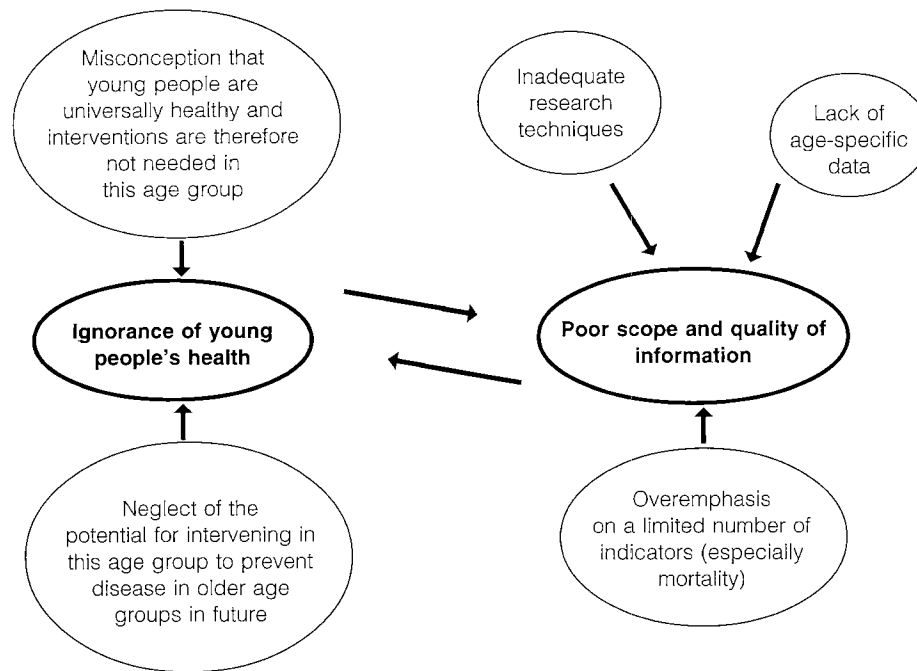
Managing data collection involves choosing the sample for study, designing good questions, ensuring reliability and validity of findings, pre-testing of methods, instruments and equipment; and important logistical and ethical considerations.

As the above information is seen as a foundation for setting programming priorities, the lack of systems in place to routinely collect basic health status information is an important initial issue to address. In many countries, the data collection systems already in place do not disaggregate their results by age and sex, and changing this system may be difficult. Part of the challenge is to present convincing reasons why the collection of adolescent-specific and disaggregated information is needed. Moreover, in many places, data categories relate only to children and adults, and therefore the data needed to support the case for addressing adolescent problems frequently do not exist, resulting in the so-called "measurement trap" of Figure 4 (25). A similar situation has been recognized in women's health (208).

It is important to note that data on adolescents may become outdated more rapidly than data on other groups. Adolescents themselves are going through a period of rapid physical, psychological and social change. As a group, they tend to be receptive to new ideas that can alter attitudes and behaviour. Therefore, secondary data that are supposed to describe their perceptions may not be accurate.

Factors other than inadequate or outdated data make the identification of priorities for adolescent health programming challenging, and require careful scrutiny. These include environmental factors, such as social and political attitudes towards young people, and the media coverage given to specific health issues. Health issues associated with a prominent public figure or ones that have been the subject of a highly publicized event can bring positive or negative attention to an

Figure 4
The measurement trap



Based on a similar diagram for maternal health in Graham and Campbell (208).

adolescent health issue or programme. The release of the results of a local or national study may highlight a particular health issue or situation, affecting the thinking of opinion leaders, and the perceptions and concerns of the general public. The priorities of donors also affect the selection of programming priorities. Donor community opinions influence policy-makers not only because of the need for resources, but also because such opinions are themselves valuable indicators of societal concerns. In any assessment process undertaken to inform priority-setting, an attempt should be made to understand which problems are perceived as important and why.

Several countries are tackling the various challenges of identifying priorities for action in programming for adolescent health. A common feature of successful country efforts to assess the situation of adolescents is the establishing of an interagency, cross-sectional task force or collective body of some type to jointly assess the country situation, improve data collection systems, and initiate a planning process. In Brazil, a task force on adolescent health was set up with multisectoral representation. Many kinds of decisions need to be taken and acted

upon if adolescent health is to be effectively advanced. Proactively assessing the adolescent health situation and making decisions on how to address specific adolescent development, prevention and care needs can help avoid some adolescent health problems and reduce others. Decision-makers in adolescent health programming require adequate and reliable information on a range of areas before decisions about programming can knowledgeably be made. These include facts and figures on the adolescent health situation, current sectoral responses (including the provision of opportunities and support for adolescent growth and development) and on the social and political factors influencing adolescent behaviour.

Conducting a situation analysis (Box 24) is a very useful means of providing the information needed to identify evidence-based priorities for action. Moreover, a full description of adolescent health status within a country provides a solid foundation of information in areas of health concern. Against the background of all the factors discussed above, there are several specific issues that are particularly challenging in conducting a situation analysis, and these are discussed below.

Box 24

Conducting a situation analysis

Establishing a sound information base on the health of adolescents through situation analyses in different settings is now an urgent priority. Using adolescents themselves as the primary source of information and involving them in researching and formulating programmes will ensure relevance, acceptability and long-term effectiveness. Creating a sense of ownership on the part of the community and of adolescents themselves is the key to successful implementation of programmes which will be enthusiastically and constructively received. A situation analysis will need to explore several kinds of information, including:

- the sociodemographic status of adolescents in the population;
- the social and physical environments in which adolescents live;
- the current status of adolescent health and development;
- predominant patterns of adolescent health and development behaviour;
- current policy and legislation of relevance;
- major interventions for adolescents in the health and related sectors, and the extent to which they reach young people;
- the capacity of various sectors to expand the coverage of some programming, to expand the scope of interventions offered, and to offer technical assistance — knowledge of existing intersectoral collaborations and successful partnerships will also be useful.

Box 24 (continued)

A WHO guide has been prepared to enable programme planners and managers to carry out a rapid situation analysis on adolescent sexual and reproductive health so that programmes may be designed or improved on the basis of sound, up-to-date information (209). Various methods and procedures are proposed which may be freely adapted and flexibly implemented according to the needs and resources of each setting. The guide focuses on the sexual and reproductive health of adolescents in recognition of the fact that the initiation of sexual activity is an almost universal feature of this second decade of life, and that becoming an adult sexually is central to overall health and development. It is emphasized, conversely, that adolescents' sexual and reproductive health has to be seen and dealt with in the broader perspective of their overall health and immediate environment, across sectors such as health, education, welfare, the legal system, and employment. During the planning phase, the objectives need to be defined, and the core issues identified. It is imperative to seek approval from the authorities, establish a technical advisory group and steering committee, and determine and select the situation analysis team. A planning workshop can be convened to further elaborate and clarify these issues. The potential users of the findings of the situation analysis, and potential strategies for data collection must be identified. It is necessary to establish a workplan for conducting the situation analysis through data collection and analysis and for using the findings. The first major task of the operational phase of the situation analysis is to collect existing information. The availability, quality and location of this information needs to be assessed. This is crucial in terms of cost because gathering information which already exists is incomparably cheaper than collecting new information. If gaps and weaknesses are identified and it is decided that this missing information is vital and must be obtained, only then should the collection of new data be considered. Following the analysis of data, it will be necessary to draw conclusions — bearing in mind that these will form the basis for public health action. The situation analysis team needs to examine the findings and determine what issues are important, what can be changed and what people want to change. This requires very careful sifting of evidence to extract the essential points and make judgements about essential actions to propose. In the third and final phase — using information from the situation analysis — a strategy for dissemination must be formulated, the reports (preliminary and full) written, and follow-up action planned and initiated. The potential users or "stakeholders", identified in the planning phase should receive the reports immediately in order to ensure the prompt and widespread use of the findings.

8.2 Data collection and analysis by age and sex

Even though age and sex are critical determinants of adolescent health status, the collection of age-specific and sex-specific data does not occur in many countries. This may be due to the limited capacity

to collect any basic health-related data. Where capacity does exist the collection of age and gender information may not be regarded as a priority, and the resulting data cannot be subsequently disaggregated accordingly.

Age-specific and sex-specific information is in fact vital to fully understanding the issues experienced differently by males and females, and at different ages. Most large national studies which have included all age groups have, however, not identified young people as a specific group in the presentation of results, nor presented results by sufficiently narrow age ranges for the 10–24-year-old age group data to be extracted. One particular problem is the lack of data collected for young people between the ages of 10 and 15. Such a lack of specific information is problematic when attempting to understand, for instance, the start of sexual activity and rates of pregnancy, as well as information on school attendance, levels of formal/informal employment etc. It must be noted that the lack of sexual health data collected on unmarried as well as married adolescents can give a false picture of the reproductive health needs of young people.

In many studies, the age groups used have been 0–4, 5–14, 15–44 and 45 and above. The use of such standard age groupings (and even five-year groupings) is not appropriate when considering events among young people. For instance, when the maternal mortality ratio in extensive studies is broken down by one-year or two-year age ranges, it has been found that the maternal mortality ratio is very high at 13 and 14 years, remains high for 15- and 16-year-olds, and begins to approach the lower ratio of 20-year-olds from age 17 onwards. Dialogue between researchers and policy-makers must be initiated so that the precise information needed is elicited in surveys and studies, and appropriately grouped.

Age-specific service statistics for health clinics also provide valuable data, though this represents just a small percentage of all adolescents as most do not use such facilities. Such data can, however, identify service use, the health needs of young people, and even health outcomes. Health outcomes from such records have been tracked in Nigeria, Puerto Rico, and the United States, for example (68).

8.3 Compiling data from different sectors

It is important that data about adolescents be obtained from all relevant sectors because no single sector deals with all the aspects of adolescent life. It is worth noting here that the term “sectors” is divided not only by the nature of the work carried out by different agencies — including health, education, and social welfare — but also

by functional responsibility such as nongovernmental, private and government sectors. Information from the various sectors can be categorized as shown in Box 25, and is vital in understanding the situation of adolescents in any setting. The limitation typically with available data is that they often omit important associations. For example, while information may exist on adolescent employment and educational attainment, it may not be possible to determine the

Box 25

Diverse sectors with important data

Governmental agencies are potential sources for information. Ministries of education may have literacy and school attendance data (by age and sex), drop-out rates for pregnancy and/or marriage, reports on availability of health education, and education guidelines and policies. Ministries of health sometimes hold data on health service utilization, morbidity and mortality by age and sex and cause, as well as data on reproductive health issues such as abortion (and related policies), contraceptive prevalence, and STDs. The census bureau typically has population data by age, sex, rural/urban distribution, and statistics on adolescent fertility rates, and adolescent employment. Other governmental agencies which may have vital information (in some cases disaggregated) are ministries of youth, ministries of justice, national AIDS programmes, ministries of finance and/or planning or labour. When looked at together all this information begins to reveal the situation of adolescents in a country.

Intergovernmental agencies such as United Nations agencies and bilateral donors hold important information frequently in the form of large databases.

Nongovernmental agencies, which include a broad range of international and national groups and professional associations, also have important programme-specific service statistics and additional surveys and, in some cases, demographic information.

Academic institutions hold libraries of useful data produced through research, especially in the areas of medical and social sciences.

Mass media have indispensable qualitative material on perceptions, myths, attitudes about sexual beliefs, role of young people in society, violent acts committed by young people, as well as qualitative and quantitative facts about readership and audience that are useful in planning interventions.

Families and young people have their own perspective on the accuracy of the other data sources, as well their own input and information. The input of these primary groups would seem obvious, but is nonetheless often overlooked as an essential part of data collection systems (209).

educational level of employed or unemployed adolescents. The different types of data needed to plan programming interventions include:

- information on the main health and development problems of this age group;
- information on how the individual's stage of physical, psychological and social development interacts with health outcomes in their age group in the country;
- data from the different sectors serving young people in order to understand usage of the various services provided and the profile of those served; both the provider and user perspective is important in addition to a review of the performance standards of the facility itself.

It is also important to know the capacity of staff and infrastructure in different sectors to undertake the desired activities. Knowing what is possible given the skills, motivation and availability of different sectors to undertake various types of activities is critical when setting programme priorities for action.

Collecting information from the diverse range of sectors and settings as discussed in Box 25 clearly takes time, effort and money. Fundamentally, such collection also requires the vision to see that it is the consolidation of the pieces of information into a meaningful whole, from the diverse sources noted, that helps planners to really understand the situation of young people and to make informed programming decisions.

8.4 Systematically involving young people in assessing priorities

The direct involvement of young people in programmes meant for their benefit is one of the most important principles in programming for adolescent health and development. Real participation is only achieved when those involved are informed, consulted and preferably encouraged to decide and manage. Young people are not only the central stakeholders, but are also a key resource. Their participation is necessary to ensure the relevance of efforts, enhance commitment, improve coverage and quality, and is of value to their own development. They should be involved from the start as full and active partners in all stages from conceptualization, design, implementation, feedback and follow-up. A youth perspective is vital to the process of understanding how issues and needs — and often priorities — are seen by young people. Young people may perceive and define their health problems differently from the way adults interpret problems based on the results of surveys of health status and risk behaviour.

The adage “what adults see as problems, adolescents often see as solutions” (177) reinforces this point.

Progress is now being made in including the views of young people within the situation analysis process described in Box 26. Many sectors, including NGOs and governments seem to see the benefit of holding focus groups with young people, and of determining their viewpoints through surveys. There is, however, less experience in youth participation in the assessment process, and in the priority-setting which follows. Several reasons contribute to the lack of direct youth participation in these processes. Some of these are logistical (such as the non-availability of young people trained in this type of task) and some attitudinal (for example, the belief that training for

Box 26

Involving young people in priority-setting — some examples

The West African Youth Initiative has an important component in Ghana and Nigeria, a partnership amongst NGOs and Advocates for Youth, which is an attempt to build the institutional and programmatic capacity of local NGOs to address adolescent reproductive health in their communities. Equally important to improving organizational capability is strengthening the abilities of NGOs to adequately and appropriately meet the needs of adolescents. It has been the experience of Advocates for Youth, one of the cosponsors, that a didactic, top-down approach from adult service providers has a rather negative impact on youth. An important focus of the efforts in the overall project is to encourage the programmes involved to look at youth differently — not as problems to be solved, or as recipients of direction from adults, but as partners in a process of solving problems and developing life skills that will positively affect their health. Part of the work has been to encourage adults to reorient their thinking around adolescents, and look for ways to value and encourage young people by providing them with complete, unbiased information on sexuality and reproductive health, and access to services as needed. In addition, each project has been required to find ways to significantly involve youth in the planning, implementation and evaluation of programmes through the training of peer educators and the establishment of youth involvement mechanisms such as youth advisory committees.

The World Organization of the Scout Movement is an example of a global youth membership organization that aims to offer youth-centred programmes, and has made progress in increasing the role of the youth in the organization's decision-making process. The World Scout Bureau recognizes that youth participation is a challenge for organizations, even those with a mission to encourage such participation. It is easier for adults to think they have the answers, “know the truth” and simply need

Box 26 (continued)

to tell young people the right things to do. It is easy to feel need to "inculcate youth with a set of values". The youth-centred approach involves youth in the process of running the organization and shaping its directions and activities. Such an approach shares responsibility with youth and provides guidance. For scouts this is an ongoing challenge; however, important progress is being made. To increase the participation of youth in the management of youth serving organizations, scouts have established specific measurable objectives to monitor progress on this aim, for example, the number of youth participants by region attending international conferences. Such efforts have encouraged country associations to raise money to send young people, not just adults, as delegates to important international scout meetings. Training adults in how to use a youth-centred approach is also a vital aspect of scout programming.

The Mentor Foundation, a group established to develop, encourage, support and sustain novel problem prevention activities among young people, addressing all types of substance use, decided at its creation to establish the Mentor Foundation Youth Advisory Group. The objective of the group is to advise the Foundation in its global effort to prevent youth substance abuse. The group will act as an expert advisory body to the Foundation and its board of trustees to reinforce the link between the Foundation and its target population. The implementation plan for this advisory group provides a useful example of the use of such a body at the international level. Many of the features of this body's set-up would also be worth emulating by such groups at the national and local levels. There are several noteworthy aspects of the manner in which this body is being established:

- Careful attention is given to the composition and selection process of youth members to reflect the target group of the Foundation with regard to nationality, social background and gender.
- Trustees of the Foundation will be asked to support the participation of individual members of the youth advisory body, taking on responsibility for financial aid, support and encouragement for their work within the group.
- Youth member orientation and training will be offered for five and a half days at a central location. Focus will be on increasing comfort and confidence in the youth advisor role, and building skills in basic leadership, management of meetings, and networking.
- Duties of youth members are clearly defined and there is a plan for communication of the group's input to the board of trustees.
- A plan is established to maintain regular contact with youth members.
- Evaluation of the orientation is built into the process.

The group will meet twice a year, after the initial orientation and training, to consider issues referred to them by the board of trustees. In addition, the Youth Advisory Group members will be encouraged to introduce issues for the board to consider.

these purposes is not the best use of training resources, or the belief that such involvement is not appropriate for young people). To help overcome the attitudinal barriers, there is a need to reorient adult perceptions about adolescents, as well as shift the media portrayal of adolescent issues away from a problem-centred focus and towards a more positive view of young people as a valuable resource. Adults need assistance to recognize that young people have valuable contributions to make. Interventions which address the attitudes of adults who work with young people would, therefore, help to clear the way for meaningful youth involvement. Of course, more feedback on the experiences of programmes that have engaged young people in all stages of the programming process would be invaluable.

Although participatory approaches involving young people have been strongly endorsed as effective by the scientific community, much remains to be learned about how best to put them into practice in countries with very different needs, cultures and infrastructures. The systematic involvement of young people remains the exception rather than the rule. The extent to which young people can be involved or actively participate in implementing programmes ranges from complete non-involvement (where they simply are the subjects of the intervention) to a situation where real decision-making is shared with adults.

In principle, interactive and participatory methods such as focus-group discussions and individual interviews provide opportunities for eliciting young peoples' personal observations and opinions. However, as discussed above, where there are both cultural and political barriers to such open discussions, and deeply rooted norms of respect for elders or leaders, such participatory methods may be difficult to conduct. It should also be recognized that young people may be reluctant to give personal information for fear that the information will find its way back to their families or friends. Social control is still strong in many areas, and young people who are not conforming to strict social expectations are likely not to say anything that could risk this being found out. Therefore, both the perceptions and reality of adult and adolescent attitudes and expectations of participation need to be addressed.

Despite these obstacles, there is growing consensus that programming improves when young people are seen as resources and advisors, and their input is systematically integrated into the process of identifying actions to improve adolescent health. However, doing this will require a new approach — a new way of seeing and doing things.

The provision of training and ongoing support in effective ways of working with young people may ensure that the shift towards involving young people is welcomed and does not become a source of concern to those unused to the idea. It must also be recognized, however, that young people quickly become adults and their places will need to be taken by others. While this constant change requires a special effort, it will also help to invigorate and maintain programme relevance and credibility, and therefore contribute to maintaining programme implementation — an issue discussed in section 9.

8.5 Determining the target groups

Interventions may be generalized (provided to all), selected (offered to a subset believed to be at risk) or targeted (directed to those at highest risk). All young people are not the same. They have different needs and priorities by age, phase of development, sex, as well as vulnerability, both personal and contextual. Moreover, “windows of opportunity” (those times when the health-outcome benefits of intervening are optimal) vary by age and sex. Understanding the needs of particular groups of young people and the key ages for various interventions is therefore important to using resources well and to setting priorities.

It is also important to note that there is some fluidity in the circumstances that place young people at risk, especially in rapidly changing conditions. For example, some adolescents may be on the street struggling to earn some money because of financial difficulties at home. A few weeks later if the financial situation improves, the same adolescents could well be off the street, and in school. Another group of school-going young people in a stable community could be displaced as a result of a conflict situation.

Finding the right balance between promoting the health and development of all adolescents, especially the younger ones, helping groups at high risk, and dealing with young people who are already ill or injured is a significant challenge. Different public health philosophies on the societal benefits of reaching young people at low risk, or aiming to reach those deemed to be at particularly high risk of different health problems, will profoundly influence priority-setting. Political and cultural concerns influence who gets interventions first, or at all. Attitudes towards various populations of adolescents and misperceptions can lead to lack of resource allocations and such attitudinal problems may have to be tackled first, before the case can be made to give attention to a particular group.

The implication of a youth development approach is that communities should put the vast majority of their resources into developing and strengthening core supports and opportunities that are in the end critical to the positive development of all young people. These supports and opportunities are part of their basic rights. Yet additional, immediate, and sustained attention should be paid to those who are in vulnerable situations and environments. Thinking of young people as being at high, medium, or low risk of health problems, and subsequently considering the same basic interventions for all the groups, and additional specific interventions for medium-risk and high-risk groups, may aid the programming process. Such an approach recognizes that some individuals are in more difficult circumstances than others, but also broadens the goal to reach those at medium and lower risk as well.

Unfortunately, there is a significant lack of data regarding who and how many people are at what kind of risk, and hence regarding where interventions are needed. For example, reaching young people who do not attend school is a chronically unmet need in many places. Often programming ends up involving the same group of school-attending young people through multiple interventions in different settings such as in school, in activities involving young people in church, and in meetings of scouts and girl guides. Such programming is very beneficial for the young people participating. However, it does not reach the many other young people who need to be reached. Careful categorization helps planners to see that the most vulnerable young people may not be served at all, and that more attention is required to find and support activities to reach adolescents who have been overlooked.

As in all health programming areas, cost and cost-effectiveness are important considerations when determining the targeting strategy. It is also necessary to consider not only what can be done at low cost, but also what programming costs are warranted based on the likely benefits.

9. Maintaining implementation

9.1 Background

Many youth programmes get started, but very few last beyond their first five years. One informal survey carried out by the International Youth Foundation suggests that less than 20% of pilot projects last more than five years (M. Alexander, personal communication, 1997).

Often programming is too ambitious in the start-up phase when funds are available and sets up staffing patterns and activities that will not be sustainable past the pilot or start-up period. Getting a stable and sustainable programming system in place is particularly important with adolescent health because there is a natural turnover of the population served, and much remains to be learned about second, third and subsequent generations of programmes with strong youth participation. The frequent pattern of repeating start-up and pilot projects is self-defeating. The pattern can also be distressing for adolescents themselves, for whom trusting relationships with adults are severed when activities cease. This is especially difficult for those without other significant adult relations or a history of being abandoned by adults.

It should be noted that there are factors that contribute to organizational sustainability that do have relevance for programmatic sustainability, which in turn is determined by an additional set of specific factors. Some of these factors are presented in Table 6. However, in some cases organizations and/or programmes may perpetuate themselves without maintaining relevance and effectiveness.

The next sections look at some of the issues which present challenges to the implementation and sustainability of activities.

9.2 Fostering adult-youth partnerships

Adolescents are no longer children and not yet adults. This is the key to understanding both the importance of adults in the lives of adolescents as well as their role in programming. For healthy development adolescents require support and opportunities to assume adult roles and behaviour. Programme activities that involve young people and adults in partnership are critically important because this:

- develops local capacity and future resources — youth participation with adults in programmes that affect adolescents' lives and the welfare of their communities is an ideal domain to gain knowledge and skills that will benefit not only the adolescents but also their families, communities and future offspring.
- monitors relevance — involving young people in programme planning and operation helps adults in their communities and in organizations stay in touch with the changing realities young people face and adapt to in these circumstances.
- maintains legitimacy — commitment by adults to meaningful youth involvement demonstrates respect and appreciation for

Table 6
Some features of sustainable programmes

Operational	Programmatic
<ul style="list-style-type: none"> • Long-term vision and planning — a common difficulty is that programmes limit their planning and vision on the basis of current funding constraints or donor interests. Successful programmes tend to have a long-term vision and plan to achieve their objectives beyond current funding. • Inclusive style of leadership — programmes are often run by charismatic individuals (often the founders) with a tendency to dominate the management and become “indispensable”. While a visionary style of leadership is effective in the first phase of a programme, long-term sustainability depends on decentralized and inclusive leadership. In addition, there is need to plan for successors. • Financial sustainability and realistic budgets — from the outset, programmes should develop a long-term and diversified plan for income generation. The plan should be consistent with the goals of the programme and avoid reliance on any one source of support. • Staff development and recruitment — burn-out is common in this field because most youth health workers are underpaid and in very stressful and emotional jobs. There is a critical need to provide staff opportunities for growth, development, and renewal. At the same time, young people should be recruited as resources for the future. • Monitoring effectiveness — ultimately, programmes should only be continued if they are effective and making a positive difference in the lives of adolescents. Programmes should develop ongoing methods to evaluate their impact and make necessary adjustments. • Staged rate of growth and expansion — effective programmes are often encouraged to expand, which introduces a series of new challenges. Experience has shown that expansion or replication should be demand driven and paced according to the existing capacity and infrastructure. 	<ul style="list-style-type: none"> • Youth participation — programmes that involve young people in planning, decisions, and implementation maintain their relevance and are viewed as more legitimate by the community and stakeholders. • Responsiveness — the programme should be initiated in response to the needs and desires of the community and adolescents it serves. It should include features which encourage feedback from the participants and other stakeholders and the flexibility to adapt to changes. • Building on local resources — as far as possible, programme activities should utilize existing infrastructure and team up with complementary organizations. • Working in multiple settings with multiple actors — to provide the best chances for positive youth development, there is a need for coordination among the key settings and actors that influence adolescent health (home, school, youth groups, peers, health services, government etc). Working in multiple settings and with multiple actors promotes coordination and prevents duplication. • Strengthen local capacity — programme activities should be planned with the understanding that the organization or programme may die out. From the beginning, the programme implementers should aim to transfer knowledge and capacity to local individuals, families and community organizations. • Training — related to strengthening local capacity is the need for training of all individuals who interact on a regular basis with adolescents and their peers. These individuals need both knowledge about adolescent health and development and skills of interpersonal communication, especially effective listening.

(M. Alexander, personal communication, 1997)

young people. It also ensures the programme's credibility among youth (the target audience) and legitimacy in the community.

Youth participation is in fact key to maintaining programmes and projects in adolescent health, as increasingly acknowledged by governments, programme planners and communities themselves. However, there is not enough documented experience of adults and young people working together in each step of the programming process, particularly in the areas of planning and making decisions, setting priorities, and overall management. While there is a lot to learn from this area, some programmes have already made the development of meaningful roles for young people a programming priority.

A major obstacle to developing adult-youth partnerships occurs when adolescents feel they are being patronized by adults oblivious to their need to be "somebody". Adolescents report that they often experience treatment by adults that seems to suggest that they really don't matter. This issue is fundamentally a question of power, whereby adults (including parents) seek to maintain control. "It causes resentment, because young people want to be taken seriously, against this stifling political climate" (R. Rajani, personal communication, 1995). In addition to this, the Convention on the Rights of the Child (see Annex 2) with all its articles is not always accepted in some countries, as accepting a degree of autonomy among adolescents is often very difficult for adults.

Perhaps first and foremost in the partnership between young people and adults is ensuring an environment of trust and mutual respect. Achieving this requires a better and more widely disseminated sense of what it means to be an adolescent in contemporary society, and of the positive contributions to society that young people can, and do, make. At the same time, creating the conditions of a "learning environment" for both adults and young people may involve relatively simple issues, such as basic respect, a participatory ethos that fosters trust and open discussion, and slight shifts in attitude. Asking adults to think about their own experiences at 14 and to recall how it felt to be young can also be beneficial. How did the adults in their lives relate to, and treat, them? What was helpful, and what was difficult? If young people and adults exchange roles in this way, then they may gain a better understanding of the perspective of others, and of their issues and concerns. Consider what mechanisms are in place to ensure/monitor youth involvement. Encourage young people to recognize the potential benefits of partnering with adults, especially mentoring experiences. A paradigm shift away from somewhat auto-

cratic top-down leadership and management helps enormously, as does dealing openly with any adult ambivalence towards young people.

In order to equip adults to explore topics, to provide information as needed on human growth and development, and to respect the decisions of young people, it is necessary also to respect their feelings and concerns, and to help them better understand the position of young people. Basic training is needed for adults on how to listen, and to practise this before they assume facilitator roles with young people or start to train peer leaders or educators. These desired characteristics of adults in their partnership with adolescents is illustrated in the findings of the evaluation of the World Organization of the Scout Movement that reviewed the characteristics of scout leaders, among other issues, through three in-depth case studies in different countries. As expressed by young people, what they appreciate and seek the most is a relationship based on greater active listening and communication on a more equal footing than what they often find at school or at home (185).

A study conducted by ICRW in the Caribbean found that while programme implementers commonly recommended involving the “clients” or young people in the process, they rarely did so (48). A partial explanation of this paradox is the lack of experience and knowledge about how to successfully include young people.

The following are mechanisms to foster adult-youth partnerships at the programming level:

- Openly explore what youth involvement will mean to the programming effort in a particular situation — build time into programme planning to clarify why youth involvement is important and consider what roles young people will play.
- Avoid tokenism — clarify meaningful roles for young people, for example in strategic planning discussions on who best reaches who to gain support for the programme. It may be, for example, better initially for adults to talk to religious leaders.
- At the outset, identify what mechanisms will be used to ensure continuous youth input to the programme (if using committee-based methods, ensure that young people are made full members), and develop an agreed checklist to monitor youth involvement, and adult and youth satisfaction with the process.
- Include a place for young people to meet in groups from the beginning to overcome difficulties for the young (as for all groups with little power) to be heard.

- Explore mechanisms for accountability — include and treat seriously youth involvement process indicators, and after one year review the progress of the involvement process.
- Consider ways to promote youth involvement at all levels. If country planners are keen to foster programming for adolescent health, then develop ways to include youth involvement in the strategic planning process, and demonstrate what this means in the programming process.

Gaining support from parents and the community early on and involving both groups in some way throughout the process will help prevent a backlash later. If the community loses trust that the programmes are in keeping with acceptable practices, regaining support can be difficult and this can disrupt continuation of the programmes. Building in processes to increase awareness, and thereby gain support, thus contributes to sustainability.

An example of reinstating supportive adult-adolescent partnerships after a reprehensible breakdown of a trusting relationship between teachers and female students was supported by the Tanzania-Netherlands Project to Support HIV/AIDS Control (TANESA), an NGO in the Mwanza and Magu districts of the United Republic of Tanzania. Through narrative research done by TANESA, and the complaints of the school AIDS committee in these districts, it was reported that male teachers were having sexual relations with schoolgirls. To decrease the vulnerability of schoolgirls, a female guardians programme was initiated by the regional educational authorities in the Mwanza region. The guardians, who are female teachers, were selected on the basis of age, teaching experience, approachability and manner and were trained in counselling skills and sexual and reproductive health. An early evaluation one year after initiation of the programme has indicated that of the 61% of girls who contacted a guardian, sexual harassment by boys was the most common reason (stated by 59%), followed by sexual harassment by men (13%) and by teachers (9%). Of course, additional problems discussed included STD/AIDS (35%), pregnancy (32%) and pregnancy prevention (22%). The guardian programme was considered very successful by both teachers and girls and while the sexual offences in schools may not be legally addressed as yet, the negative publicity surrounding such events is thought to make it more difficult to harass girls in this way now. This programme strategy has subsequently been adapted to provide guardians (male teachers) for boys as well in the schools in this region (210).

9.3 Reorienting and sustaining existing interventions through training

The orientation, training, coordination, and continual development of people who interact with young people is critical for adolescent health programming for several key reasons:

- First, individuals working directly with adolescents provide role models for both positive and negative behaviour. Intentionally or unintentionally, these individuals can influence the young person's self-image, perception of adults, health-related decisions, and many other lasting beliefs.
- Second, throughout the day many people interact with adolescents in a variety of settings (home, school, youth groups, health services, workplace, cafeteria, etc). All of these actors have potentially significant influences over the positive development of adolescents and should understand the goals of health programming to ensure coordinated efforts.
- Third, training should be an important component of the programme from the outset in order to transfer knowledge and capacity to local individuals, families and community organizations. This will have the added benefit of ensuring programme sustainability beyond the life of the project.
- Fourth, training and personal development opportunities help avoid burn-out and disillusionment among staff and volunteers working with youth. Too often programmes are jeopardized by heavy turnover or staff that have not dealt with their own problems and/or prejudices. Work with adolescents is typically characterized by low pay, long hours, and emotional stress. Individuals working with adolescents need opportunities for personal renewal, stimulating learning/professional development, and support from colleagues.

In order to be effective, people who interact with adolescents need knowledge about adolescent health and development, including the sensitive topics of sexuality, and use and abuse of substances, and this must be allied to interpersonal communication skills, especially effective listening. Some will need specialized training (in counselling, for example), but for many, short-term training with experiential techniques can help create the required sensitivity. Often the training, follow-up, and ongoing supervision of people working with the young are not considered programme priorities. As a result, one persistent obstacle has been a lack of knowledge of adolescent maturation among those who work with young people, and poor interpersonal and counselling skills, including the inability to be nonjudgemental

when faced with adolescents of whose behaviour they disapprove. There is often a special discomfort in dealing with the sensitive but crucial subject of sexuality. Efforts to promote adolescent health are frequently undermined by the damaging myth that giving young people information and services related to sensitive issues such as sexual behaviour and the prevention of pregnancy and STDs will make them promiscuous — a myth which persists despite scientific evidence to the contrary.

There are, in addition, particular training issues in reorienting the scope of programme interventions specific to different settings. One example is teachers' resistance to adding family life education programmes to their workload. Some teachers resist because they feel curricula are too crowded, they are uncomfortable with the subject, feel unprepared to teach the subjects, or fear parents' criticism. Training time is needed to allow for discussions on attitudes and feelings about new interventions. It is important to note that teachers can be effective educators for reproductive health when properly consulted, trained and supported (211). Staff in health clinics too need special training to treat young clients in a supportive, nonjudgemental way and to help them choose appropriate methods of contraception and STD protection. Other kinds of training will be needed for different actors. These will include training in research techniques to conduct situation analyses; training for management, including multisectoral approaches and the involvement of young people; better understanding of methods to achieve sustainability; and training in techniques for monitoring and evaluation, specific to adolescent health.

A number of countrywide programmes have already been successful in sustaining their activities through training and related reorientation strategies (Box 27). The technical capacity to develop interventions and to train adolescents and adults in how to implement them can be facilitated through linking the programme with other agencies, including universities, which can assist with capacity-building and training in many places.

9.4 Coordinating activities in multiple settings

The experiences discussed so far with approaches to enhance adolescent health and development show that there has been a burgeoning of projects on adolescent health. However, there are few examples where the complete range of interventions has been implemented in the diverse settings where such interventions should be made available. It is a challenge to coordinate existing efforts and build on them because of their multidimensional nature, diverse priorities and

Box 27**Importance of training in sustaining programmes**

A country-wide programme in Jamaica successfully introduced an adolescent peer-led multiple interventions curriculum in reproductive health. The need for ongoing training for new groups of peer educators each year was addressed by developing a two-tiered training model which prepares trainers to work in teams to run peer educator training in their local areas throughout the country. Distinguishing features of the programming process included careful development and field-testing of the basic peer-led curriculum, as well as the development and field-testing of the workshop designs for training the peer educators and the master trainers. The development stage took time, but by the third year of the programme return on the initial investment showed exponential growth with 250 peer educators working in teams conducting multisession interactive sessions with their peers, engaging them through interactive information and skill-building interventions, referring peers to health services as needed in urban and rural areas. Process evaluation was vital at each stage of development to ensure that the materials, training methods, and selection criteria of peer educator and trainer candidates were satisfactory.

Such a training system offers a way to prepare trainers who can lead workshops and prepare others to implement the designated interventions on a wider scale. An essential feature of the capacity of this programme to offer extensive coverage was that the Red Cross network was already in place around the country and had active youth participation in many aspects of the work of the organization. Nonetheless training sessions to sensitize adult volunteers in the organization to the youth participation goals of the programming were still critical, with some adults better able than others to accord the youth a serious role in the planning, implementation, and evaluation stages. The written materials and training guides for each level of the training system, as well as plans for selecting educators, are essential features of a training system that does not rely on the same small group of people, often needing to work from a central location, to train peer educators. This programming is very promising, but will need to be in place longer for its implementation capacity to be fully assessed over time (Jamaica Red Cross & American Red Cross, unpublished data, 1995).

In Brazil, the National Adolescent Health Programme maintains that successful implementation relies on the orientation and training of personnel at all levels. It developed a strategy for training which involves three stages:

- Sensitization — this is a 40-hour training workshop orienting professionals to adolescence, the needs and concerns of adolescents, the framework of the programme, the priorities for adolescent care, etc.;
- Capacity building — involves training sessions which focus on specific adolescent concerns such as growth and development issues, mental health, reproductive health, etc.;

Box 27 (continued)

- Course for facilitators — this session is designed to train skilled professionals to train others and is often conducted in cooperation with the universities. In 1991, SASAD (Servico de Assistencia a Saude do Adolescente) developed a sensitization manual and, in 1993, a technical guidebook on adolescent groups and participatory techniques. Supported by PAHO and assisted by trained facilitators, SASAD has established an interdisciplinary team of professionals and boasts at least one nucleus providing integral health care for adolescents (with fully trained professionals) in each state. The programme must continue to actively pursue dissemination of its training methods as there is, relative to the number of adolescents, still a shortage of trained adolescent health professionals (C. Hanson, unpublished data, 1995).

uneven relative capacities for delivery and management in different settings. Programming experience makes it clear that coordinating efforts of such complexity is not effective without a mechanism that brings together the key partners on a regular basis to define and review the implementation agenda, while sharing experiences based on the reality of implementation.

Bringing together a representative group of interested people to spearhead the process of implementation is also recommended by UNICEF (30). Such coordinating groups should include technical and managerial staff representing the settings, line ministries, research and NGO partners, as well as multilateral agencies and bilateral donors. This would facilitate reaching some common consensus in guiding concepts, programming principles, and key strategies at the national level, which in turn assists a similar process at the subnational implementation level. Typically, such coordination is brought about through a variety of mechanisms, including: national task forces for adolescent health, large enough to include members for building ownership but small enough not to get unwieldy; national coalitions of existing implementing partners, principally NGOs and other community-based organizations; national commissions which tend to be focused around defined problems such as population or safe motherhood; and theme groups relevant to young people's health and development, including existing ones for HIV/AIDS and illicit drug-related issues.

UNFPA's recent thematic evaluation of information and service programmes for adolescents shows that most governments do have coordinating units for family planning and/or population activities, with recently identified focal points for youth concerns (84).

The current experience is that coordination is taking place at the national level in several countries. This is driven by the realization of implementing partners themselves of the importance of coordinating and clarifying several issues including:

- the existing profile of current activities, partners, collaborations and the scope of efforts;
- identification of pragmatic mechanisms for coordinating effectively at national and local levels;
- the consensus on priorities, goals and implementation strategies;
- the feasible mechanisms for sharing experiences of effective practice and reflection of what works or does not work;
- the opportunities for focus, complementing and sharing of technical, managerial and financial resources of different efforts with converging interests;
- the efforts required to fill the common gaps identified through maximum use of existing technical expertise in linkage with a network of regional and, if necessary, international technical support;
- the strategies for the effective participation of young people;
- cost-effectiveness and sustainability of programmes.

In Malaysia, there are a number of creative youth initiatives under way. The diverse initiatives provide a useful illustration of activities in different settings that interrelate, but are under different parts of the government, which may present challenges in coordination. For example, an ambitious national youth initiative called Rakan Muda (youth friendship) is operated by the Ministry of Youth and Sport and aims to direct the energies of young people into a number of lifestyle programmes that have strong youth appeal, and to develop their will to resist the many current social ills (Sharifah Tahir, personal communication).

CHILDSHOPE ASIA — Families and Children for Empowerment and Development Foundation Incorporated, started with the support of UNICEF, is an example of an agency acting as a focal point to bring together many NGOs to collaborate on improving living conditions, helping families and changing community attitudes about why youth are on the streets and what their needs are, including health needs. By collaborating with WHO through its Programme on Substance Abuse street children project, this organization is expanding this base of community networks and collaboration to improve interventions related to substance use. The capacity to offer training on core issues about why youth are using substances, rapid assessment methods to better understand the needs of youth, and ways of mobilizing

community action to involve other NGOs is an important vehicle to enhance collaboration (212).

9.5 Continual recruitment of young people as human resources

As maintained throughout this document (see section 6.2), the direct participation of young people is one of the most important principles of adolescent health programming. And as already recognized, young people quickly become adults and their places will need to be taken by other young people. The systematic participation of young people presupposes continual turnover of this very important resource for programme development, delivery and renewal — a requirement that remains one of the major inherent management challenges of programmes for adolescent health. While this constant change requires a special effort, it will also invigorate programmes and help to maintain relevance and credibility.

The UMATI initiative referred to previously has been struggling with just this issue in its peer education programmes. It has recognized the importance of repeating training cycles for new peer educators and offering new roles and opportunities for “ex-” peer educators in the programme as their interests change, that is, as they grow older (N.B. Katunzi, unpublished data, 1995).

Elsewhere, peer education at Kenyatta University, Nairobi, Kenya, successfully uses printed mass media materials to increase awareness of its programme and recruit young people as peer educators. The *KU Peer*, a student-run magazine, deals with a variety of health issues, such as substance use and abuse, sexual and reproductive health, reduction of violence, and other important social issues on campus. Informative articles and editorials written by student peer counsellors address issues which affect older adolescents and aim to increase young peoples’ knowledge about healthy behaviour. The publication also serves to enhance the social status of the peer counsellors by highlighting their services and activities, thereby contributing to the students’ motivation to become peer counsellors. Printed in collaboration with Pathfinder International as part of the Kenyatta University Family Welfare and Counselling Project, the magazine reaches over 20000 readers in universities, colleges and schools throughout Kenya. The magazine has increased awareness of the active and respected peer programme, noting for example that the programme coordinators were processing 5000 applications from young people who wanted to become peer educators throughout the Nairobi area (213).

Part of interesting young people on an ongoing basis is keeping topics current and flexible in response to the interests and changing needs of young people. Programming models the in-country need to operate with some flexibility, training teachers, leaders, and volunteers on how to gain access to information. Community resource people can also assist leaders to feel prepared to respond to a range of health topics within programmes. The Tunisian Ministry of Education has been successful in establishing school health clubs with active youth participation based on the philosophy that the content areas covered need to be responsive to the expressed issues, topics, and concerns of the young participants. Teachers are taught how to engage students directly in seeking information. Thus, if students want to work on a potentially unplanned topic they have to determine where to get the information, the speakers to invite, community sites to visit, and other agencies or groups that may be able to help them. This approach is reported to have helped maintain the interest and participation of young people in the programme (144).

9.6 **Achieving large-scale programming**

While effective adolescent health and development programmes exist throughout the world, they are reaching only a fraction of those in need. How can these programmes be adapted, expanded and/or replicated so that more young people benefit? According to the experience of the International Youth Foundation (review of 132 youth programmes from over 30 countries), a programme's reach is typically extended in one of several ways: increasing the number of programme locations; increasing the number of young people served in an existing location; and broadening the impact of a programme through networking by using existing infrastructure, or linking a number of independent programmes that offer similar or complementary services. Numerous examples exist of programmes that have successfully expanded or replicated their approaches — locally, nationally, and internationally.

In recent years, programme managers and funding agencies have been increasingly concerned about achieving long-term impact and sustainability, and have been exploring the possibility of adapting “best practices” to facilitate this. As previously mentioned, the International Youth Foundation review revealed that in 1990 some 80% of the funding worldwide for youth programmes was directed at innovation rather than replication. Only 20% of these “pilot programmes” survived past five years. There is wide agreement that it makes sense to stop reinventing the wheel and invest instead in replicating and/or scaling-up “best practice” programmes with adaptation. However, the

term “replication” is problematic, in part because few agree on how to replicate and even fewer on its definition. In 1990, the C.S. Mott Foundation produced a special report, *Replication: sowing seeds of hope*, which provided an analysis of four common strategies of programme replication: the “cookie cutter” or franchise, the adaptive approach, dissemination of a concept, and networking.

- “Cookie cutter” or franchise — this approach is designed to establish identical programmes in many locales. Typically, “cookie cutter” replications are coordinated by a central organization that keeps a tight rein on individual sites to ensure uniformity and quality of both the delivery of services and outcomes. Perhaps more typical among youth programmes is a somewhat less rigid version that allows for adaptation. For most social programmes, cloning, imitation or other forms of “exact” reproduction are neither feasible nor desirable.
- Adaptive approach — with this strategy the intent and integrity of the original programme is maintained, but latitude is permitted to adapt the programme to different needs, constituencies, or other cultural elements. One such programme is Youth as Resources, a community service model that was developed in the United States, which is successfully being adapted throughout Poland. Another example is provided by the findings of the evaluation of the World Organization of the Scout Movement, referred to earlier in this section, that also reviewed scouting’s educational impact on adolescents. In all three in-depth case studies of different countries, the findings indicated that the ultimate educational benefit depended on the local leader’s ability to adapt the scout method in a way that met the needs of the young people in the context within which he was dealing with them (185).
- Concept dissemination — this highly flexible replication strategy is to disseminate a concept and exert little, if any, control over how specific programmes are developed at specific sites. An example from Latin America is the concept of “street education” as a way to reach street-based and working children. Street education is an approach used alone or, more often, in conjunction with multi-staged programmes. There are as many ways to conduct street education as there are street educators. However, the dissemination of information, technical assistance and networking among street educators has been critical to the improved quality of service.
- Networking — like concept dissemination, this is a flexible approach to encourage adaptation and replication of good

programmes and practices. Through networking, linkages can be made between organizations that result in rapid interactive learning as well as the spreading of particular approaches or models. An example of this approach was the “technical support group” process, an interagency collaborative effort supported by UNICEF from 1993 to 1995 to accelerate organizational learning and this improve UNICEF’s response in the areas of adolescent health and development and HIV/AIDS. The close involvement of key partners, including United Nations agencies, foundations and other technical organizations, was a critical feature particularly for an area of work where effectiveness could only be achieved through a sharing of knowledge in a way that transcended narrow organizational interests and agendas. Where between 1991 and 1992 no UNICEF office was involved in supporting programmes on HIV/AIDS for adolescents, by the end of the technical support group’s mandate in 1995 there were at least 35 annual country reports that had ongoing initiatives for adolescents, youth and HIV/AIDS (214, 32). The International Youth Foundation has put a strong emphasis on the need to encourage networking and information-sharing about best practices for positive youth development. In 1991, the foundation initiated an international network of successful youth-serving programmes worldwide. Given the importance of cultural context, the foundation has emphasized sharing programming strategies or best practice versus programme “models.”

- Building on large-scale infrastructure — this includes the school system as a key institution capable of incorporating comprehensive school health education programmes, and as recommended by the WHO Expert Committee on Comprehensive School Health Education and Promotion, to enhance the idea of a total healthy school environment that provides a safe place for students and promotes health throughout the day. The school system in a Belgian nutrition project began with 35 schools between 1991 and 1992, and expanded to cover 300 schools with 80000 pupils by the end of 1995 with no major difficulty (C. Vandoorne, A. Poumay & M.L. Nieuwenhuyse, unpublished data, 1995). In Botswana, the PACT peer education programme (previously cited) began in 11 schools in Gaborone and, within three years, was able to extend to schools in other cities and towns, targeting all schoolchildren in the country by the end of 1996. The key factors in each case were full collaboration by teachers and students, and the recognition and support by the government in meeting an identified need of young people (YWCA, unpublished data, 1995).

Some potential in-country partners to help achieve large-scale programming at the country level

The role of government as the major partner in a country may be obvious, but it is critical to mention its role and capacity in bringing successful programmes to scale. While it is worth exercising some caution about a programme becoming too dependent on government funds (better this than on external donor funds), the public sector does have a pivotal role to play in bringing successful programmes into the mainstream. Other national infrastructures include those of the ministries concerned (health, education, social welfare, gender and development, among others). Specific to young people in several countries are ministries of youth and health or youth and sports programmes. The Ministry of Youth and Sport in Malaysia and the Vietnam Youth Union have provided excellent networks for achieving large-scale programming, and with strong youth participation.

In addition to the public sector, there are a number of significant national NGO partners operating at the national and subnational levels in all countries, who would also be logical and important partners because of their outreach to communities, and their potential for local networking. Other partners would be the international organizations, with youth participants, that have national networks in place throughout the world; they include the Scout and Girl Guide movements, YMCA and YWCA. There are also those international organizations such as the Red Cross and Red Crescent which have a mission to reach out to young people in communities, and multilateral agencies such as UNICEF. Another international NGO that offers programming support to country offices and specific programming areas of reproductive health including for adolescents is IPPF. The value of being part of an international network is not only for the opportunity to learn, share and work with counterparts in other countries, but also for the economies of scale in sharing prototypes of materials and programming guides to facilitate training and technical assistance. Moreover, a significant international presence is often beneficial for access to interested donors and consequently can help with funding.

Factors that contributed to successful expansion of projects and programmes

The following examples of specific projects and programmes illustrate a variety of factors that are considered to have contributed to the programmes' successful expansion. These examples have all been previously described in this report.

- Government support has been an important element in most of the projects, both for expansion and sustainability. PACT Botswana, which started as a YMCA activity funded by the Swedish International Development Cooperation Agency (Sida), subsequently diversified its funding base to several international donors and has finally started receiving government funds from the Ministries of Education and Health as well as the Population Development Council of Botswana (YWCA, unpublished data, 1995).
- Advocacy by project managers with national leaders has led to expanded support, as is evidenced by several efforts including the achievement of PACT in getting national government support. This was possible because of the strategies of targeted advocacy to politicians, senior policy managers, headmasters, teachers and government departments concerned with population and development. Other examples are initiatives such as “Cities in Schools” in the United States, (8), “Butterflies” (8) and “Project Alternatives” (D.C. Kaminsky, unpublished data, 1995).
- Multisectoral partnership between the Government of Uganda, UNFPA, and selected NGOs is exemplified in the implementation strategies of the Programme for Enhancing Adolescent Reproductive Life (215), which started between 1995 and 1996 as a pilot effort in four districts, and will now extend to four districts per year for the next four years 1997–2000.
- Strong leadership and management combined with confidence built up by the project is illustrated by SERVOL (G. Robinson, unpublished data, 1995b).
- Guaranteed financial stability for expansion is illustrated by the Belgian nutrition project (C. Vandoorne, A. Poumay & M.L. Nieuwenhuyse, unpublished data, 1995).
- Capacity-building was a feature common to most projects, and particularly in UMATI (N.B. Katunzi, unpublished data, 1995) which managed to extend a training model progressively in selected districts. All projects developed their own curricula and guidelines which were used in the expansion process.
- Youth and community participation was common to all these projects, and was considered by organizers to be a critical factor in their success.
- Independent client demand for activities has been identified as an important factor to consider since expansion will only be successful if implementation activities meet actual demand and genuine needs.

Some examples of large-scale programming

A number of projects have been integrated in existing countrywide institutions or systems which lend themselves to expansion once the methodology is accepted and found useful. Some examples are:

- The mass media, as in the *Dehleez* radio project in India, specifically targeted young people with a serial drama aiming at increasing their awareness and knowledge on sexuality and reproductive health issues. Including interactive participation from listeners, the programme was very popular and successful and is being widely expanded by Air India, which will translate it into local Indian languages. Radio is one way of reaching all rural areas, and this project also demonstrates the success of a national NGO working with the private sector — commercial radio — towards wide coverage of important youth health programming (G. Giridhar, unpublished data, 1995a).
- Local youth clubs were created by the Vietnamese Youth Union using the national decentralized administrative structure to cover all the districts in the country. More than 1000 clubs have been created, each of which is expanding independently within its own community. The major factors are strong government support and a project design built on “youth participation,” an acknowledged key to success (C. Serrano, unpublished data, 1995).

Sustaining large-scale programming

There are no easy solutions to the often raised issues of how to sustain a programme over time. Concerns about sustainability are on the agenda of most governments, organizations and donors, and certainly communities, and still require operational clarity and some best practice examples. However, there are some typical components of projects and programmes that are considered to contribute towards their sustainability. These include: financial, contextual (relevance, political commitment, responding to local needs), institutional (capacity, technical expertise), human resource (capacity and management), environmental (impact) factors.

The financial sustainability of projects has been the first and obvious issue that earlier studies have focused on and continues to be the major concern of donors. Typically, since financial sustainability is often assessed during the lifetime of the project or programme, reviewing its viability is commonly a look into the future, based on current trends. Expecting financial sustainability in the short term is not realistic for most projects and programmes. It requires an orientation from the start of minimizing dependency on external donors,

and at the very least “spreading” the funding base among several donors.

One concrete effort to enhance financial sustainability is cost-sharing, a relatively new trend which has led to new partnerships for funding, involving communities (216) and mass media as well as the corporate sector (119).

The area of institutional capacity and capacity-building has also received attention, though it is not easy to describe analytically as the methods and tools for assessing this have not been effectively explored, identified and developed. The gaps in this area of work need to be addressed through systematic networking and experience exchange of efforts between all partners: donors, multilateral agencies, governments, NGOs and research institutions. However, there is some tentative evidence that the ability to achieve institutional sustainability may often be linked to the ability to achieve financial sustainability as well (217).

10. **Monitoring and evaluation**

10.1 **Background**

Many stakeholders increasingly want to know what precisely is being achieved for all the effort and resources invested in programmes. Policy-makers and service providers want to know what the programmes cost, how they are functioning, how to maximize complementary input and minimize duplication and they want to base their decisions on data and evidence. Monitoring and evaluation are critical functions for precisely this purpose, for providing the evidence of what is happening based on data that can be collected by all interested parties. The importance of both processes to any systematic programme strategy development and implementation is becoming increasingly apparent. Thus good monitoring and evaluation will not only ensure that programmes are made accountable to all stakeholders — including communities, programme staff, governments, agencies and donors — but will also provide operational feedback to ensure strategic reorientation and enhancement of specific interventions. Above all, there is an urgent public health challenge to understand the complex interactions of all the various factors that contribute to positive adolescent health and development outcomes, so as to revise programme strategies accordingly, thus improving intervention effectiveness. For all these reasons, programme monitoring and evaluation are vital.

Monitoring and evaluation should be undertaken to get information for making decisions and taking action. Even when data are systematically collected, too often valuable resources are allocated to the collection process rather than to the analysis, interpretation and use of the information. Only data that are usable should be collected, to allow alternative uses of scarce programme resources. It is important also to track not only what is being done (and how) and what is being achieved, but also what is not working, and why. Well-designed monitoring and evaluation thus enable us to capture planned and unplanned results of activities, whether positive or negative, and the reasons for them. It is equally important to learn from what did not work rather than concentrate only upon what did, which is the usual approach. To be of maximum value, monitoring and evaluation should be built into programme development from the outset and be an integral part of the planning process. The clearer the objectives, strategies and specific targets of the programme, the more feasible and useful monitoring and evaluation will be. In addition, the ongoing monitoring of process and outcome, coupled with periodic evaluations, is more valuable than a single post-completion evaluation. Monitoring and evaluation have both been defined in various ways depending upon the particular aspects of each that those working with public health programmes wish to emphasize (Box 28).

Monitoring and evaluation are needed at international, national and local levels since the information necessary for international comparisons, advocacy, national target-setting, and public mobilization will not often provide answers on what types of interventions need to be undertaken at local levels. Thus, a more detailed and varied set of issues should be considered particularly at subnational levels, in order to address specific development aims and challenges. There is an increasing need for equal partnership and dialogue between donors and developing countries to define emerging adolescent health and development concepts as consensus is sought on how to measure and document successful efforts that are youth-centred, focus on positive development, foster positive relations with adults, and build on existing local resources, among other initiatives.

Increasingly, the cultural and interpretative nature of many of the changes in adolescent attitudinal and behavioural outcomes that are desired calls for the use of complementary qualitative information to support the more traditional quantitative statistical information that has typically been collected. Qualitative data should be collected and analysed with scientific rigour to better evaluate programming for adolescent health and development. This is very relevant where health and well-being, in addition to mortality and morbidity

Box 28**Monitoring and evaluation — some definitions****Monitoring**

WHO defines monitoring as the continuous follow-up of activities to ensure that they are proceeding according to plan. Some programmes further specify inclusion of “the process of measuring what services a programme is providing, how much service a programme is providing, who is providing the services, and who is receiving the services” (218). According to UNICEF (219), monitoring is “the periodic oversight of the implementation of an activity which seeks to establish the extent to which input deliveries, work schedules, other required actions and targeted outputs are proceeding according to plan, so that timely action can be taken to correct deficiencies detected”.

Evaluation

To evaluate means “to ascertain the value or worth of,” according to its Latin root. Knowing what difference programmes are making motivates workers and their supporters to renewed effort. Although evaluations may be retrospective, they are essentially forward looking with regard to their purpose. Evaluation applies the lessons of experience to decisions about current and future programmes. Good evaluation presents alternatives for decision-makers to consider. Evaluation can be an excellent learning tool as well as a means to improve programme performance and demonstrate accountability. More formally, evaluation is a process which attempts to determine as systematically and objectively as possible the relevance, effectiveness, efficiency and impact of activities in the light of specified objectives. It is a learning and action-oriented management tool and organizational process for improving both current activities and future planning, programming and decision-making (219).

Programme evaluation can be considered as the systematic assessment of the relevance, adequacy, efficiency, effectiveness, and impact of a programme. The WHO Programme on Substance Abuse defines process evaluation as the assessment of the workings of a programme, intended to answer specific questions about the operation of a programme (218). Two of the most important questions are:

- are planned activities actually occurring?
- is the programme meeting the needs of the target population?

Outcome evaluation is undertaken to discover whether the short-term objectives of the programme are being achieved. Most outcome evaluations are focused on determining changes in behaviour and/or health status.

statistics, become the focus of attention. Qualitative methods are needed to assess such programmatic issues as the degree of youth participation, the degree to which a multisectoral approach has been implemented, changes in the views of influential people in the community as well as young people themselves, and changes in policy arising from programming results. Thus qualitative data can provide vital information on values, norms, knowledge and principles of action used by social actors including adolescents, to interpret their experiences and provide meaning for their practices and social interactions (220). The techniques that are mostly used for qualitative data collection include observation, in-depth interviews and discussion (focus) groups. Quantitative and qualitative data together provide a more detailed and relevant picture of what is happening, why this is so and what could be done to improve the situation for adolescents and their communities.

In general, large-scale surveys have been regarded as the method of choice for formal programme evaluation. Such quantitative surveys permit the collection of data from large numbers of people in standardized ways, enabling comparisons between communities, countries and time periods. Alone, however, they are often insufficient in providing the type of in-depth information required to understand the complexity of human behaviour, and to formulate prevention and control strategies and programmes. As discussed elsewhere (221), qualitative information needs to be generated on the same topics in a way which permits a more detailed, a more rapid and, often, a more accurate understanding of the underlying social and cultural characteristics influencing or associated with specific patterns of behaviour (222).

It can sometimes be difficult to get people to see the usefulness of monitoring and evaluation because these activities may be seen as academic exercises that are time-consuming and costly, and require highly trained specialists to conduct or interpret them. In fact, local officials and community groups frequently engage in informal monitoring and evaluation, and strengthening existing skills and activities may be all that is required for an effective evaluation component. Demystifying the evaluation process is likely to enhance its acceptability and is the first step in building ownership of the process and results, so that people are convinced of their own value and assume decision-making responsibility. Training community leaders in evaluation can strengthen their ability to plan and carry out development activities (223). Such approaches lead naturally to the development of local capacity, an issue which has consequences and repercussions not only for monitoring and evaluation but for all aspects of implement-

ing programmes. One lesson to emerge from direct experience has been that evaluation results are far less useful unless those who use them are involved in the planning and implementation stages of the evaluation (224).

Common barriers to conducting evaluations include:

- inadequate funding to finance data collection and analysis, design of information systems, technical assistance or hiring staff with expertise in evaluation;
- limited or no institutional commitment to evaluation because staff see little value in evaluating, beyond justifying expenditures to donors;
- limited time for staff to design and make an evaluation plan operational;
- confusion over which methodology to use (to measure either process or outcomes);
- lack of adequate evaluation models to adapt to their programmes;
- weak programme design and management, making it difficult to define what should be done and what should be monitored and evaluated;
- inadequate indicators for measuring outcomes for adolescents.

It has been pointed out (65) that the public health sector often has naive expectations of the effects of massive health promotion. In industry, even a 1% change in market share can be a major success. In public health, measurement tools are only able to detect substantial change, and thus many mass education campaigns are rejected as unsuccessful, although in the long term they might have considerable consequences on public health status. For example, even a tiny reduction in the proportion of smokers would represent an important investment in extended life and lowered health costs. In increasingly resource-constrained countries, the need for even more accurate and sensitive monitoring and evaluation of programmes designed to improve the quality of human life has never been greater.

In the area of adolescent health and development where behavioural outcomes are often context-specific, programme monitoring and evaluation can provide an underlying and systematic understanding of the concerns of young people, as well as of the issues and situations they have to face. Although the problems that young people experience — arising, for example, from sexual behaviour and relations, violence, and the use of tobacco, alcohol, and other drugs — share a number of common antecedents, the extent of occurrence and the nature of such problems are greatly affected by environmental

influences. The effectiveness of interventions in mitigating or enhancing these environmental influences can be determined by monitoring and evaluation. Such information can be used to make changes, or to provide justification for continuing effective interventions.

Monitoring and evaluation should be used to design interventions that respond to the needs of different groups of young people as well as demonstrate the value of involving young people in planning, implementing and evaluating these interventions. They also provide feedback on the prevailing attitudes of the community — teachers, parents, and other figures — towards the programmes: how a multisectoral approach is being achieved; how community support is being obtained and sustained; the community's successes and its problems. Such information can be used to make changes, or to justify continuation of effective interventions.

Equally important, proper monitoring and evaluation can provide documented proof that a programme is reaching young people (coverage), that it is valued by them (quality), and is effective (that is, having a positive impact on knowledge, attitudes, behaviour and health). Such results help gain support from a wide range of actors, including government, communities themselves, and donor organizations.

An example of a project that takes into consideration the influence of the environment in mediating the violence experienced by youth and has a monitoring and evaluation framework as an integral component of its plan of action is the Chicago Project for Violence Prevention. This project draws on the strengths of the youth themselves in solving problems in strong partnerships with their communities (families, police, city authorities, vocational training and job support), the health system, the education system and the judicial system.

This project provides targeted focus on the highest-risk youth offenders to provide them graduated sanctions, with community monitoring and policing, supported by the police, that also provides protection to previous and likely victims. Vocational training opportunities are provided, with supervised after-school skill development and recreational programmes as well. The youth are offered opportunities to participate in meaningful roles in their communities and job support. Strong emphasis is also placed on promoting and enforcing norms against violence through community public education.

As the Chicago example illustrates, monitoring and evaluation in the area of adolescent health programming does present very special challenges for a variety of reasons (see Table 7). These programmes address a diversity of problems, often include multiple agencies and

Table 7

Youth violence — evaluation example from Chicago Project, United States

Goals	Strategies→	Strategy indicators→	Intermediate indicators→	Outcome indicators
Safety	*Crises network *Firearms reduction *Probation/control *Vulnerable locations	*Notification and responses *Effectiveness *Hot spots monitored	*Circumstances avoided *Firearm carrying	
Opportunity	*After-school programmes *Job linkages and support	*Availability of youth programmes — after school — job support	*Youth in productive activities or heading towards them	↗Safe places, times ↗Feeling safe
Norms	*Public education — no violence — specific alternative actions	*Messages distributed and received	*Behaviour in specific circumstances	↘Number of assaults ↘Number of killings
Care	*Mentoring relationships		*Youth with caring adult	

(G. Slutkin, personal communication, 1997)

clients, and change over time to meet evolving needs. Moreover, working with adolescents who are at a critical development stage around puberty can involve highly sensitive topics that could create controversy within communities (G. Slutkin, personal communication, 1997).

Some of the tried and tested methods of conducting evaluations with adults do not work as well with young people, and new and creative data collection methods that are interesting to young people without being intrusive have to be designed. In addition, the monitoring and evaluation approaches used need to involve young people in participatory and interactive ways, and this itself poses special challenges for measurement. Again, where adolescent behavioural outcomes are often context-specific, many established methodologies for collecting data are often not easily transferable or universally applicable to all cultural settings. The process of sharing experiences between so-called “developing” and “developed” countries needs further facilitation as there is a lack of documentation on sharing of experiences specific to developing country settings. Obstacles to this process have included language differences and a lack of appreciation for cultural diversity and the differing views about adolescence. Some programme-related issues that pose challenges for the evaluation of adolescent health and development programmes include (225):

- Defining programme participation and unit of analysis — participation in youth programmes is difficult to define as many programmes have flexible entry and exit points. Furthermore, it is not clear whether gains to be made by indirect programme beneficiaries such as parents, boyfriends and girlfriends should be evaluated. Experience has shown that participants should be followed from the point of entry and all major programme activities should be tracked.
- Evaluating the relation between participation and outcomes — assignment to treatment groups in many programmes is based on individual need and is not random, with adolescents with the greatest problems receiving the most intensive services. This renders comparisons of outcomes to nonusers or to less frequent users inappropriate. Data on risks and needs of participants should, therefore, be collected at intake for use in a pre-post design.
- Tracking the services received by participants — in order to track the effective integration of services, documentation of referred clients is essential, but is time-consuming and difficult, requiring written agreements on information sharing.
- Developing common agreements among organizations on programme goals — it is essential to generate a consensus amongst the agencies on programme goals and strategies prior to programme start-up.
- Documenting service delivery by multiple agencies — a system for collecting data on who received what type and amount of service needs to be developed early in the planning process.
- Measuring effects of the service delivery system — evaluations have to be able to measure the extent to which services have been integrated.

Because of the life cycle stage that adolescents are at, the benefits of interventions designed for them may only emerge decades later. While only a longer-term evaluation would determine the impact of interventions, this requires an investment of time and money which some might prefer to have allocated to more pressing needs and problems, requiring immediate attention and resources.

An innovative programme for adolescents that has had a recent formative evaluation after one year of operation is the Government of Uganda's Programme for Enhancing Adolescent Reproductive Life (PEARL), supported by the UNFPA country office (226). PEARL seeks to enhance the reproductive health of Ugandan youth (10–24 years) by providing appropriate health and counselling services and by encouraging district and community leaders to take an active role in implementation actions. It had been implemented on a pilot basis in four of the 39 districts of Uganda by December 1996, and a phased

expansion to four additional districts per year is planned for 1997–2000. The four broad areas of intervention for PEARL are:

- the sociocultural and political environment;
- the adolescents themselves;
- provision of reproductive health counselling services;
- coordination and capacity-building.

PEARL aims to create an adolescent multipurpose community centre which will facilitate the growing-up process if a welcoming and supportive sociocultural and political environment is cultivated; if adolescents are equipped with peer counselling skills and tools; if quality reproductive health counselling and information are made available by well-trained personnel; and if a sustainable, coordinated capacity in youth-friendly reproductive health service delivery is developed.

It should be noted that the very early evaluation of the PEARL programme, one year after it started operating, does not permit sufficient time to see significant or sustainable results. It would be best to repeat the evaluation at least two years later to confirm if trends still appear to be moving in the directions indicated below:

- There is an increasing demand for counselling and health services. Adolescents are able to discuss freely previously taboo subjects such as unplanned pregnancies and post-abortion complications.
- There are reduced reproductive health problems and ramifications, changes in the health-seeking attitudes and behaviour, and improvements in adolescent perception of risks, particularly those related to unwanted pregnancy, incomplete abortion, STDs, and HIV/AIDS.
- The task-focused, inclusive and participatory approach (the PEARL concept) adopted at all stages of programme implementation has facilitated a deeper understanding of adolescent reproductive concerns and their integration into the existing community service delivery systems.
- Involving adolescents as implementers and maximizing community resources and existing health services have proved to be cost-effective.
- Human resources development and institutional capacity-building have taken place at both central, district, and subcounty levels.
- The institutional network has facilitated a quick spread of programme activities to a sizeable proportion of the community in the pilot districts. The PEARL approach has had a multiplier effect and has been introduced in non-pilot districts through collaboration with other programmes such as Family Life Education and the Safe Motherhood Initiative.

A UNFPA global report on adolescent reproductive health programmes (84) has recommended that collaborative research efforts should form an intrinsic part of programme monitoring and evaluation. Such collaborations could be made between programmers and “outside” academic institutes and other agencies which can conduct research. The report — on adolescent reproductive health in eight countries — found that when university or major NGO sponsorship was involved, evaluations tended to be of high quality, whereas when the project was on its own, very casual assessments were made. The report also identifies three major weaknesses remaining in the monitoring and evaluation of adolescent reproductive health programmes:

- Critical gaps remain in the issues covered.
- Data collection and presentation have failed to disaggregate age groups, which masks important differences in behaviour and needs.
- Findings are not made available for use in programme and policy formation.

The report recommends that these weaknesses could be minimized by involving a lead agency to oversee the research agenda. In addition, data collection methods must disaggregate by sex and age groups — even the age group of 15–19 is too broad, as the experiences of 15-year-olds are very different from those of 19-year-olds. Finally, research findings should be widely disseminated, and one way to do this is to create a clearinghouse for the dissemination of findings as well as for the undertaking of research.

10.2 Establishing and using indicators

In order to facilitate systematic monitoring and evaluation, it is necessary to make indicators part of the design of the programme from its inception and planning phases, as mentioned above. This is typically made operational through a situation analysis or assessment to establish the existing (baseline values) situation for adolescents and the problems that require interventions. This leads to the development of a programme plan with the definition of desired objectives to be achieved, an implementation plan with specific intervention efforts and a monitoring and evaluation plan as indicated in Box 29. Indicators are a critical part of this process and their specification should flow from the objectives and activities planned, paying attention to how they will be measured. The measurement process is, therefore, centrally dependent on the definition and selection of indicators, on the basis of which the results of actions are measured. The measurement takes into account both the process and outcome of efforts.

Box 29**The course of monitoring and evaluation**

For monitoring and evaluation to be effective, it is first necessary to establish a baseline of information, which is essential for identifying changes. Ideally, the results of a full situational analysis should be available as a result of the process of assessing priorities for action — as described in section 8. At the same time, systems to monitor and report information learned have to be set up, and decisions taken on what health information will be monitored. The information that programmes are asked to routinely provide must be seen to be useful, and worth the time and money required to collect it. The ways in which such information is to be used must also be made clear from the outset. All of this represents a major challenge because there is often no consensus on what information should be collected. The following sequence summarizes these and subsequent steps in the overall process of monitoring and evaluation, and represents a generalized and abbreviated version of the approach currently adopted by UNICEF (222).

Tasks during the situational analysis stage concern the:

- identification of baseline data or means to collect them;
- aggregation and disaggregation of data analysis of trends and prospects;
- analysis of needs and identification of constraints and possibilities for action.

Tasks during programme preparation involve:

- ensuring that objectives are as specific as possible;
- developing indicators to define success or progress;
- planning monitoring and evaluation;
- assessing national capacity for monitoring and evaluating programmes;
- providing opportunities to share, review and use results.

Tasks during programme implementation include:

- ensuring that data collection is proceeding according to the monitoring plan;
- reviewing regular progress reports with managers, comparing actual progress with intended progress;
- identifying additional training, technical assistance and other resources that are needed;
- providing feedback to concerned parties.

Tasks during programme evaluation involve:

- evaluating outcomes;
- discussing the evaluation with appropriate ministries and other partners in the programme;
- reaching agreement on the audience and purposes of the evaluation;
- obtaining agreement on the terms of reference;
- ensuring the implementation of the recommendations, and use of evaluation results in present and future programmes.

Box 29 (continued)

Outcome has been defined (226) as changes observed at the population level among members of the target population as a result of a given programme or intervention. There are two types of outcome:

- Effects — these are changes in the short term to medium term (2–5 years) in a behaviour promoted by the programme.
- Impact — these are changes that occur over the longer term in fertility, morbidity, or mortality rates — or “the overall effect on health status and socioeconomic development” (WHO glossary).

“Indicators are descriptors of projected outcomes, products, or changes that are used as observable evidence to measure the impact of interventions . . . Indicators are facts, opinions, events, etc. that define the standard performance, or that should be attained in order to obtain the results planned” (227). Indicators are more effective when they are defined from the planning stage so that objectives may be defined to be measurable. When this is not possible, but the indicator is considered to be important, a method has to be developed for its measurement. An indicator contains the following elements (212):

- the participants or beneficiaries targeted for intervention (who?);
- the qualities/behaviour/conditions/competencies which will change/occur/develop (what?);
- quantification or how much change will occur or how many (how much?);
- the time period during which the change will occur (when?);
- the location of the target population (where?).

For example: the number of (quantification) low-income young women aged 15–24 (beneficiaries) participating in revolving credit programmes (qualities) in Machala city (where) by the end of a 12-month period (time); number of meetings held (quantitative); sense of self-esteem (qualitative). These indicators provide a point of reference for ongoing monitoring during the 12-month period, as well as evaluation (at the end of 12 months of whether targets were achieved and why, or if not, why not).

No clear consensus has yet been reached on what should be the set of core indicators for use in assessing and monitoring the health and development of young people. This has hampered cross-country and

intracountry comparisons. There is, however, agreement that the indicators chosen should be feasible, valid across cultures, repeatable, and preferably simple and inexpensive (25). The capacity to monitor indicators is clearly an issue in many countries. Rather than obtain a little information on a wide range of indicators, it will be more valuable ultimately to focus on a few indicators related to national priorities for adolescent health and for which accurate data can be obtained.

Traditionally, the main “health” indicator used by health planners, policy-makers, researchers, and programme staff has been mortality. Although the collection of data on mortality and morbidity levels is very important, there are distinct limitations to their use as the main indicators of adolescent health. The importance of the health and health-related behaviour of young people will be grossly underestimated if the only criteria used are the current levels of mortality and morbidity. In addition to such measures, it will be necessary to employ, to the fullest extent, indicators of positive health, behaviour, and of adolescent development, all indicators being disaggregated, where feasible, by age and sex.

Indicators are needed in the areas of adolescent sexual and reproductive health, the use of tobacco, alcohol and other drugs, eating habits, oral hygiene, nutritional status, suicide and aggression against others. The development of positive indicators of well-being, health and development is a particular challenge, and the systematic collection of information on the health-related behaviour of young people will be a crucial step towards this. In fact, adequate research and intervention programmes cannot be developed until at least four categories of data on young people are obtained:

- health related — such as mortality, morbidity and disability;
- subjective — such as reported perceptions of illness and of risk to self;
- behavioural — such as tobacco, alcohol and other substance abuse, sexual practices, general and oral hygiene, diet, exercise, use of protective devices, interpersonal skills, stress management;
- positive indicators of well-being, healthy outcomes and development.

It is also necessary to know not only what the main health and development problems of this age group are but also how the individual’s stage of physical, psychological and social development interacts with health and disease in this age group. To this end, large-scale population-based surveys have been useful in collecting information

and learning about adolescent health issues in many developed countries. In some countries, this has been done by studying the associations between risky behaviour, emerging lifestyles, and the major morbidities of adolescence and adulthood (228). However, when applied specifically to young people, limitations in such surveys have emerged, and these include:

- reliance upon secondary sources or proxies to document information about the health of adolescents (usually parents, who may not have first-hand knowledge);
- failure to include the full age spectrum of young people (disagreement as to what “adolescence” means; different and non-comparable age cohorts being sometimes aggregated despite important differences between early and late adolescence);
- surveys not being distributed to a representative cross-section of adolescents (for example, a drug survey carried out in school does not reach the high-risk, out-of-school population);
- difficulties inherent in measuring the health of adolescents — how is “health” defined/conceptualized in adolescence? Some researchers (229) have concluded that in adolescence, complete self-sufficiency is not expected and age-appropriate cognitive, psychological, social and physical development are more important considerations.

There is a need also to work on programme process indicators. It is vital to involve young people in the decision-making process, and for such participation to become one of the key programme process indicators that are systematically monitored. If clearly linked to a programmatic framework, these and other indicators may become readily useable in setting priorities. The goal to strive for is to systematically monitor and evaluate action through sensitive and feasible measures/indicators, so that what is learned can be shared and utilized to make programming efforts optimally responsive and cost-effective.

As described by the evaluation project, Carolina Population Center (226), good indicators should:

- suggest not only the extent of the problem but also its nature whenever possible;
- include the causes of mortality; however, measures of health and well-being should also be included;
- be relatively easy or cheap to obtain;
- include measures of risk and harm;
- be both direct measures (those associated with long-term goals) and indirect measures (objectives that are needed towards achieving long-term goals).

Furthermore all indicators must:

- actually measure the phenomenon they are intended to measure (valid);
- produce the same results when used more than once to measure precisely the same phenomenon (reliable);
- measure only the phenomenon they are intended to measure (specific);
- reflect changes in the state of the phenomenon under study (sensitive);
- be measurable or quantifiable with developed and tested definitions and reference standards (operational).

In measuring indicators, methods which are adolescent-specific, and relatively quick and simple to use, need to be employed. As these methods become available through scientific advances they can be introduced as part of training of those responsible for evaluating programmes. A few instruments have been developed which measure health indicators and health-related behaviour specific to adolescents. One example of an instrument which measures adolescent health-related behaviour on a national scale is the Youth Risk Behaviour Surveillance System (230), developed by the United States Centers for Disease Control and Prevention.

In terms of mortality and morbidity measures of selected health problems, potential indicators include (25):

Reproductive health

- maternal mortality ratio among adolescents under 17 years;
- percentage of young women with first birth under 20 years;
- young people's knowledge about human sexuality, contraception, and STDs;
- percentage of sexually active young people using contraception/condoms;
- percentage of pregnancies among young women under 20 years ending in abortion;
- percentage of persons aged 10–15, 15–19, and 20–24 years with the classical STDs;
- percentage of persons aged 10–15, 15–19, and 20–24 years with HIV infection;

Endemic diseases (tuberculosis)

- incidence of sputum positive cases in young people (10–24 years);
- proportion of diagnosed cases among young people completing treatment;
- tuberculosis-related death in young people;

Mental health

- incidence of acute psychosis in young people;
- percentage of young people with “psychosomatic” complaints attending health facilities;
- attempted suicide rate in young people;
- completed suicide rate in young people;

Tobacco use

- percentage of young people, by age, who have ever smoked;
- percentage of young people, by age, who are regular smokers;
- age of starting smoking among 20–24-year-olds;
- attitudes and knowledge about smoking among young people.

What is needed eventually, however, is a set of indicators of adolescent health status that, when taken together, will allow not only the monitoring of the major causes of mortality and morbidity but will also allow a country to focus on the health and well-being of its young people. Examples of indicators of well-being might include behaviour such as seat belt or condom use, or measures of literacy and caring or connectedness (the extent to which the young person feels connected to at least one adult; see Box 30).

More specific factors may need to be analysed for programme monitoring purposes — as distinct from health status identification and monitoring. The following example provides an overview of a randomized, controlled, intervention trial that will monitor and evaluate impact indicators (health and behaviour change) as well as programme process indicators (the delivery of key interventions and the role of key actors in that process).

One community-randomized multiple intervention trial to reduce sexual risk behaviour and the prevalence and incidence of HIV and other STDs in adolescents is being undertaken in rural communities in the Mwanza region, United Republic of Tanzania, based upon random selection of intervention and control communities and before and after intervention comparisons. The research design for this trial is that similar communities will be randomly selected to have interventions or not have interventions (control communities). The communities with interventions will be compared against the control communities. Moreover all communities will be surveyed before and after the implementation phase. This is one of the few HIV/STD/adolescent pregnancy prevention programmes that specifically target adolescents in the developing world (148).

The specific value of this “gold standard” trial is that it will include a rigorous health impact evaluation which no other programme to date

Box 30**Some indicators for adolescent health***Positive indicators*

- acquisition of life skills (self-esteem/sense of belonging/self-worth/knowledge to make healthy decisions, caring or connectedness, i.e. the extent to which the young person feels connected to at least one adult);
- seat belt use;
- condom use;
- reproductive/sexual knowledge among adolescents;
- adolescents affording services;
- belonging to an appropriate peer group;
- number/type of agencies serving adolescents;
- adolescents counselled by qualified staff on reproductive health;
- educational attainment rates.

Negative indicators

- prevalence of HIV/STDs among adolescents;
- rates of abortions among adolescents;
- prevalence of substance use;
- percentage of adolescent-headed households.

In addition to such direct measures, there are important proxy indicators such as the extent of school enrolment, employment, housing status and family structures, as well as environmental conditions which may be subject to changes resulting from policies and programming.

has undertaken. All other related programmes have sometimes reported improved knowledge and behaviour, but have not measured the resulting health impact. This is for a good reason, however, since health impact measurements are well known to be very resource- and time-consuming. The establishment of causality requires measurement in a cohort with a carefully selected comparison group, doubling the survey sample. Furthermore, measurement of changes in health status, particularly decreases in HIV incidence and prevalence (expected to be 2.5% in the comparison group in three years), entails some stringent minimal sample size requirements for cohorts and comparisons. In addition to this, as is typical for cohort follow-up studies, taking into consideration typical drop-out rates (in this case estimated to be 20% or 30% in three years) increases the initial sample size requirements.

However, once a trial such as the one in Mwanza establishes the linkage between interventions, subsequent behaviour change, and

finally health impact, it establishes the causality case for other intervention programmes. It is in principle no longer necessary thereafter to prove again that such interventions are beneficial to the health and well-being of adolescents, which is of great benefit for other intervention efforts. Therefore, this trial is very timely since the information that it will provide at the end of the programme (planned to be five years from the baseline survey with a three-year follow-up period after the interventions are in place) will be invaluable for others who are implementing similar efforts. The three main interventions are:

- school-based health education on sexual and reproductive health issues as part of the life-skills education curriculum;
- skills training to assist adolescents with moving from attitudinal change to behaviour change;
- provision of youth-friendly health services, including STD treatment, family planning and counselling based in the existing primary health care structure.

The surrounding community will be mobilized to support these interventions, and in-school peer educators will specifically be recruited to facilitate information and skills development for adolescents, including themselves. The impact measurement will focus on measuring the prevalence and incidence of HIV, other STDs, and adolescent pregnancies in a cohort of adolescents starting at 14–15 years, who will thereafter be followed for three years, before final measurement. In addition, the following core behavioural objectives will also be measured:

- delayed onset of sexual intercourse;
- practising safer sex by those already engaged in sexual activity;
- early recognition of symptoms of STDs and improved health seeking behaviour regarding STDs and pregnancy.

Cost-effectiveness of the intervention package will be evaluated, based on similar methods used during the previous HIV/STD intervention trial in Mwanza region. Incremental costs of the interventions will be estimated (separating intervention costs from research costs). The impact measurements will only be estimated from the initial random cohort of in-school adolescents and any benefits for the initially out-of-school group will not be measured. Therefore, the cost-effectiveness estimates will be conservative.

“Process measurement” is a complex undertaking in a trial such as this that includes multiple interventions provided in multiple settings, where the process consequently should be monitored for the combinations of these interventions and settings with the desired intermedi-

ate benefactors (health workers, teachers, peer educators) and the ultimate benefactors (adolescents). Thus process measures include those that contribute to the improved management of the programme as well as epidemiological issues pertaining to the population of adolescents and their interactions with the interventions and settings in which they are being provided.

The programme management factors include the availability, accessibility, quality and timing of the interventions being implemented. The epidemiological factors include the profile of the utilization of the services by adolescents, and the extent to which desired subgroups are being reached (extent of coverage and scope of activities). These complementary process measures are important intermediate checks on whether the conditions are being achieved in order to have an impact on adolescent sexual behaviour and health. The process indicators that need to be measured will be based on the following:

- the key players and their roles (trainers, health workers, peer educators, teachers);
- intended groups to be reached by the key players' activities;
- the essential features of the activities themselves (training, skills building, service delivery);
- the quality of the activities (content, setting and methods of undertaking these activities);
- the sequence and timing of these activities, including combined training, complementary materials as well as referral between them are key factors in the integration of efforts.

10.3 Tracking quality and coverage in different settings

The challenge of learning from effective adolescent health and development programmes is their inherent complexity in that they address multiple health problems while combining interventions in various settings with youth at the centre of all efforts. However, tracking the quality and coverage of each intervention will ensure attention towards agreeing on some minimum standards for services that are provided in a variety of settings (schools, health centres, community centres) and that should reach a sufficient number of youth. This will provide some common understanding of what inputs are necessary, the key players who need to be involved, the processes that should be monitored, and what outcomes can be expected and, preferably, at what cost.

Initially, however, consensus should be reached on the criteria for the quality of services provided to adolescents and whether an acceptable minimum standard could be defined. Services to adolescents include

health, education, information, counselling, recreational and vocational training, which are provided in the variety of settings mentioned above. Consensus on what constitutes quality services needs to be defined for each of these service areas and settings, based on some common conceptual ground (availability, approachability, accessibility, affordability, acceptability). It should be noted that each of these factors can be further categorized depending on whether it is the quality of health services or, for instance, life-skills education that is being provided. Thus, confidentiality may be an important element of acceptability for health services, but interactive methods may be the important element of acceptability for life skills.

In the past, there has been considerable confusion on the measurement of quality, which has included such diverse measures as the level of technical sophistication of services or even the potential demographic impact of services. For family planning and reproductive health care services, Bruce (231) has provided a framework based on a health service model, derived from what clients considered to be critical (choice of methods, information given to clients, technical competence, interpersonal relations, follow-up and continuity mechanisms, and the appropriate constellation of services). This framework and other aspects of what constitutes "youth-friendly" services need to be reconciled, particularly for the purpose of defining some "minimum standards" of quality that would be achievable and measurable. It would be important to bring service providers and adolescents, as well as programme managers and researchers, around the table to agree on the criteria for quality, suitable indicators for assessing these criteria, and what would be necessary to facilitate their measurement.

Not surprisingly, coverage is linked to quality, with improved utilization of services and hence increased coverage expected for a higher quality. However, agreement is required on what should be measured as coverage is not straightforward either. Potential coverage is the proportion of the population which can receive the services, while actual coverage is the proportion which has actually received the services (232). Since the interaction between services provided and adolescents who receive/use these services is complex, there can be several measurements for coverage: availability, accessibility, acceptability, contact and effectiveness. Moreover, measuring the coverage of prevention, promotion or care-related services would entail the use of different denominators because of the groups that would be targeted (for prevention interventions all adolescents, for care interventions adolescents with specific needs such as rehabilitation from substance use, or STD treatment). Prevention-oriented services will

be focused on persons or households (demographic characteristics), as the unit of consideration, while care-oriented services would have to include consideration of demographic and epidemiologic characteristics such as the “case” (pregnancies, STDs). Finally, the nature of the services themselves will define the specific group coverage (pregnancy-related primarily for females, while STD-related for both males and females).

As information is gathered on the extent of coverage of quality interventions within a defined population of youth, the issue of integration of efforts will become clearer. Of course, indicators for the integration of interventions also need to be agreed upon, including cross-referrals among services, sharing of resources such as service providers and training staff as well as materials, complementary messages, and the nature of partnerships between organizations.

Identifying programmes considered to be good examples of providing integrated interventions in multiple settings for adolescents would be an important step towards documenting pragmatic examples of what interventions are being implemented, how this is done, what is tracked for accountability, and what factors are considered to be achievements, whether measurable or not. Such systematic documentation and analysis would provide the basis for developing a framework for programming, monitoring and evaluation of adolescent health and development programmes. The Mwanza trial provides such an opportunity for follow-up even with its sophisticated experimental design with random selection of intervention and control communities and before and after intervention comparisons.

One example of an intervention programme for improving adolescent health and development outcome is the Basic Education, Child Care and Adolescent Development (BECCAD) programme of the Government of Uganda, supported by a number of partners including UNICEF Uganda. The important feature of this programme is its emphasis on a life cycle approach to the growing Ugandan child from birth through adolescence, focusing specifically on the changing social, emotional and cognitive development needs. This programme combines a national policy development and advocacy focus, with operational interventions in partnership with NGOs that have direct access to adolescents. With the current emphasis on decentralization, direct district level technical and financial support is provided for the development and implementation of adolescent focused programmes, particularly for out-of-school adolescents.

At the recent mid-term review of the BECCAD programme in Kampala (233), where a group of Ugandan government programme

staff from districts as well as NGOs, local research institutions and other United Nations partners were present, a group exercise was undertaken to identify factors that should be monitored and evaluated to follow up the progress of the programme. The three areas of intervention that were selected for discussion were adolescent-friendly services, life skills education, and mass communication. For each area, the output was a set of issues to consider for monitoring and evaluation under quality, coverage and impact. A strong qualifier was made about the consequences of measurement impact, in that it was acknowledged as an activity that should be selectively undertaken because it requires significant financial and technical resources, commitment of which is not always feasible (see Table 8).

There are several examples of good projects and programmes that seem to be improving the lives of adolescents but lack an evaluation framework on which to base decisions or facilitate adaptation for

Table 8
Tracking quality, coverage and impact — example from Basic Education, Child Care, Adolescent Development, Uganda (233)

Interventions	Quality	Coverage	Impact
Adolescent-friendly services	*User satisfaction	Number of service delivery points (per population base)	Prevalence of health problem (STDs, unwanted pregnancies)
	*Availability (services, medicines and commodities)	Number of adolescents attending and proportion of those that should/could attend	Observed behaviour (demonstration of life skills)
	*Acceptance (empathic interaction)		Level of community support
	*Confidentiality		
	*Referral		
Life skills	*Interactive approaches to teaching	Number of materials in different languages	Adoption of safe sexual practice
	*Level of interest of youth	Number of trainers trained	Incidence of HIV/AIDS
	*Involvement of youth	Number of youth trained	Adolescent development (resiliency, resisting bullying)
Communication	*Demand (circulation, audience)	Percentage of target audience reached by geographic/age/sex distribution	Reported behaviour change
	*Response (letters to editor)		Level of knowledge

further replication. One such project is the Youth Advisory Center (YAC) in Malaysia. This is an NGO which works to provide sexual and reproductive health services and family life education, and to train young people in leadership qualities. It works across multiple settings, including schools, the workplace, and the community. Although no in-depth evaluation has taken place, a general feeling of success does pervade the members of the YAC. It is felt that most youth reached by the YAC activities did benefit from their participation (234). These observations can be strengthened and supported by even some simple but strategic qualitative analyses that would identify:

- what members define as success;
- how this was achieved;
- what benefits youth participants have received;
- how these were achieved;
- what additional factors of success can be identified and measured;
- what additional benefits youth participants can receive and can be measured;
- what gaps may exist in defining and/or measuring success and benefits and how these can be overcome;
- what gaps may exist in describing how success and benefits were achieved and how these can be overcome;
- what should be avoided in adapting this project for further replication.

10.4 **Understanding the impact of young people's participation throughout programming**

Section 8.4 discussed obstacles that inhibited the full and meaningful participation of young people across the spectrum of programme activities. The technical reality is that sociocultural barriers to the effective participation of young people have created a gap even in defining meaningful participation in measurable terms, let alone following up to monitor and evaluate the impact of such participation. Thus monitoring tools are clearly needed for all aspects of young people's participation, including in assessment, programme planning and development, programme monitoring and evaluation and in the resulting impact, both for young people themselves and for the feasibility, relevance, effectiveness and sustainability of such programmes.

A first step is to define youth participation. Measures or indicators of participation then need to be developed, being mindful of their validity: do these really measure the participation of young people? This is

a big enough task, some aspects of which are already under way, if not systematically, at least through several programmatic models (mostly implemented by NGOs) and through monitoring the implementation of the Convention on the Rights of the Child at country level. The next step would be to agree upon criteria of effectiveness, impact or success as ascribed to the result of young people's participation in programming efforts. This is of course a bigger task, because agreeing upon pragmatic measures of programmatic impact is a challenge in itself, without the complexity of ascribing some aspects of this to the participation of young people themselves.

With respect to the first step, monitoring participation, it can be an end in itself for several programmatic efforts, provided that what is being measured is not "token" participation. Participation may not be welcomed in many sociocultural contexts, so facilitating participation is an important process measure prior to measuring any subsequent impact from such participation. With participation, there is some immediate impact on youth participants in their sense of personal accomplishment and skills development. There would simultaneously be an effect on the perceptions, beliefs and behaviour of the adults around these participating young people, which should also be measured as a result.

An additional monitoring opportunity is provided by the implementation of the Convention on the Rights of the Child at country level, either nationally or by countries reporting to the Committee on the Rights of the Child. This process entails the identification of a variety of indicators, including those for Article 12 of the Convention that specifically addresses participation of young people. Annex 2 includes the Convention's articles pertaining to the situation of adolescents. The articles have also been sub-categorized according to various issues, including those that deal with the "Rights to Participation". An implementation guideline has been prepared (235) for country level application in assisting governments, NGOs and other partners to understand how the Committee on the Rights of the Child interprets the Convention, and what would be expected for monitoring and reporting implementation (also Annex 2) for each article. While the focus is necessarily legislative and legal, for Article 12 the checklist that has been prepared includes several issues relevant to monitoring the participation of adolescents, particularly in regard to their interaction with the society around them.

The longer-term programmatic impact of young people's participation depends on achieving the specific objectives of the programme (behaviour and health status change, empowerment), as well as the

underlying goals of demonstrating the feasibility, relevance, effectiveness and sustainability of such programmes. To sift out the causal impact of young people's participation is a further challenge, which should not have to be established every time in such programmes, taking the well defended lessons from some "best practice" examples.

There is need to design and conduct operational research which also measures the impact of young people in specific areas of programming, namely strategic planning, intervention delivery, and monitoring and evaluation activities. Issues to address include differences in youth-led versus adult-led information, skills and counselling interventions; and the impact on the eventual programme participation levels, longevity, and behavioural outcomes when young people are involved from the planning stage. Moreover, studies on how youth-adult partnerships have successfully impacted on all areas of programming would increase the knowledge on how to enhance the effectiveness of interventions and determine useful process indicators as well.

Limited research has also been conducted on the impact of young people's involvement on programme success. One example is the National Crime Prevention Council's Youth as Resources initiative, in the United States, which aimed to provide young people with opportunities to plan and implement community projects, and to promote the notion of adolescents as community resources. As part of the project's evaluation, Youth as Resources used structured interviews which indicated that the greater the youth role in actually developing and managing the project, the greater the benefit and the more successful the project (194).

There has, in addition, been interesting research conducted into the impact of peer-led interventions in health-promotion programmes. A review of the literature on such programmes indicates that the use of peer counsellors and peer educators has been shown to be more powerful as an intervention component than the use of adults such as teachers or nurses to convey information, skills, and norms (51). Peer leaders report positive behavioural outcomes regarding their sexual practice and increase in feeling of self-worth (YWCA, unpublished data, 1995; Jamaica Red Cross & American Red Cross, unpublished data, 1995). In Thailand, it has been found that being a peer educator is beneficial for girls because it provides an opportunity to discuss sexual topics without the risk of being socially stigmatized as promiscuous (111). The West African Youth Initiative is an example of a programme which has a concise plan for process monitoring and

evaluation, and which can now point to measurable progress (Box 31). Young people need to be involved in planning, implementation and assessment of project activities not only to ensure programme effectiveness, but also as a right (94).

11. Conclusions

No longer children, not yet adults — adolescents are at a stage of rapid development when they acquire new capacities and are faced with many new situations. As adolescents face the challenges of the second decade of life, a little help can go a long way in channelling their energy towards positive and productive paths. Neglect of adolescents can lead to problems, both immediately and in the years ahead. One of the most important commitments a country can make for

Box 31

Example of monitoring youth involvement

The West African Youth Initiative

One example of a programme which is monitoring youth involvement is the West African Youth Initiative, a project designed to test the impact of peer education programmes addressing adolescent reproductive health issues. The project developed a plan to monitor and evaluate youth involvement in programme management (C. Lane, unpublished data, 1995). Putting this objective into effect includes the following indicators:

Indicator

- number of young people trained;
- number employed working as volunteers;
- duties and roles taken by young people;
- amount of time young people contribute to the organization;
- membership of young people in advisory committees;
- youth attendance at planning and organizational meetings;
- active youth participation at meetings;
- opinions of young people about their involvement;
- opinions of community members about the level of youth involvement.

Methods of assessing these indicators include:

- training records;
- minutes of meetings;
- job descriptions (even for volunteers);
- work reports;
- interviewing young people, staff, community members, clients;
- observation at project site.

future economic, social and political progress and stability is to address the health and development needs of its adolescents.

Today's world offers adolescents both remarkable opportunities and risks to their health. More than ever before, adolescents are able to attend school and benefit from technological progress. Yet the lives of millions of them are marred by poverty, inadequate education and work opportunities, exploitation, war, civil unrest and ethnic and gender discrimination. Rapid urbanization, telecommunications, travel and migration bring both new possibilities and new risks to young people. These conditions may directly jeopardize health and undermine the traditional social support that helps young people prepare for, negotiate and explore the opportunities and demands of their passage to adulthood. Society's expectations of behaviour, roles, access to resources and prospects for development vary for adolescent boys and girls. Decreasing influence of family and culture, earlier puberty and later marriage extend the risks of unprotected sex among unmarried adolescents in many parts of the world. In some countries, early marriage and childbearing lead to high maternal and infant mortality rates. In others, sexually transmitted diseases including HIV/AIDS pose enormous health risks to adolescents. Potentially harmful substances — tobacco, alcohol and other drugs — are now more readily available to adolescents and threaten their health in both the short and the long term. Violence inflicted by and on young people is a growing phenomenon. Young men frequently take part in acts of violence, including wars. Suicide attempts appear to be on the increase among the young and many are the victims of violence, including sexual abuse, often perpetrated by adults.

Adolescence is a gateway to the promotion of health. Many of the behavioural patterns acquired during adolescence (such as gender relations, sexual conduct, the use of tobacco, alcohol and other drugs, eating habits, and dealing with conflicts and risks) will last a lifetime. They will affect the health and well-being of future generations. Adolescence provides opportunities to prevent the onset of health-damaging behaviour and potential repercussions. Fortunately, adolescents are receptive to new ideas; they are keen to make the most of their growing capacity for making decisions. Their curiosity and interest are a tremendous opening to foster personal responsibility for health. Furthermore, engaging in positive and constructive activities provides occasions to forge relationships with adults and peers as well as to acquire behaviour that is crucial to health.

Health problems of adolescents are interrelated. Many of the factors that underlie unhealthy development in adolescents stem from the

social environment. They include poverty and unemployment, gender and ethnic discrimination and the impact of social change on family and communities. While programme efforts for adolescent health cannot directly focus on inequities and injustices in society, they must take into consideration the fact that these conditions are real constraints to improving the health and well-being of adolescents. The attitudes and behaviour programmes seek to influence (e.g. sexual behaviour and gender relations, use of substances, dealing with conflicts and risks) often arise from and feed off one another. For example, the use of psychoactive substances alters judgement and thus makes aggressive acts, unprotected sex and accidents more likely. Moreover, the preventive interventions for such behaviour are the same and all contribute to positive personal growth and development.

Successful programmes require support to expand their reach. While interventions still need refinement, enough is known to act now. Programmes must provide the support and opportunities for adolescents to:

- acquire accurate information;
- build skills;
- obtain counselling (especially during crises);
- have access to health services, including those for reproductive health;
- live in a safe and supportive environment.

The social environment must foster personal development, encourage young people to adopt healthy behaviour, and enable them to gradually take on adult responsibilities through participating in decisions that affect their lives and making contributions to their families and communities. Policies and the media should strengthen and communicate positive norms for both adult and adolescent behaviour, such as that related to equality and gender equity. Attention to meeting basic needs for safety, a sense of belonging and self-esteem, as well as mastering key skills for living, improves the overall development of adolescents. It enables adolescents to avoid health risks and motivates them to practise healthy behaviour. Programme efforts need to take into account the fact that adolescents are not alike and that interventions and the way they are delivered will vary according to differing needs and circumstances.

Impetus and direction for increased action for adolescent health come from many sources. The basic rights and obligations concerning the promotion and protection of the health of adolescents are articulated in the United Nations Convention on the Rights of the Child, and in the Convention on the Elimination of All Forms of Discrimination

against Women. Recent international conferences and statements such as the 1994 International Conference on Population and Development, the 1995 Fourth World Conference on Women and the United Nations World Programme of Action for Youth to the Year 2000 and Beyond further strengthen and support these rights and obligations. Furthermore, explicit measures to support, stimulate and strengthen national laws, policies and programming for adolescent health have been adopted by WHO, UNFPA and UNICEF.

12. Recommendations

12.1 Recommendations to WHO, UNFPA and UNICEF

1. WHO, UNFPA and UNICEF should promote the use of the framework for country programming for adolescent health (see Fig. 1, page 3). The framework is a graphic summary of the elements which countries need to consider in programming for adolescent health. It also highlights the key challenges of programming.
2. WHO, UNFPA and UNICEF should develop clearly defined goals for agencies' activities in support of the acceleration of national programming for adolescent health, as well as systems for monitoring the agencies' collaboration.
3. WHO, UNFPA and UNICEF should strengthen and expand collaboration at country level with other United Nations organizations and agencies (for example, UNDP, UNDCP, UNESCO, UNHCR and the World Bank) and relevant partners, including bilateral and multilateral donors, NGOs and the private sector, to support action for adolescent health.
4. WHO, UNFPA and UNICEF should support country programming on the basis of individual country priorities and situations, and should use existing processes to coordinate operational activities of the United Nations system.
5. WHO, UNFPA and UNICEF should bring these conclusions and recommendations, and related issues, to the attention of their governing bodies, and act on the recommendations, taking into consideration each organization's respective mandate, structure and comparative advantage.

Global actions to extend the quality and reach of programming

6. WHO, UNFPA and UNICEF should, at global level, strengthen the rationale for adolescent health by reinforcing the public

health and economic evidence and arguments for adolescent health programming, and thereby help increase the investment of resources in programming activities.

7. WHO, UNFPA and UNICEF should, at global level, develop appropriate indicators, and approaches for the measurement of such indicators, to be used in the planning, monitoring and evaluation of country programmes.
8. In order to bring focused, timely attention to the urgent need for information on how programming can be expanded in cost-effective and sustainable ways, WHO, UNFPA and UNICEF should make a concerted effort to support and study the experiences of individual countries that indicate readiness to expand critical aspects of their adolescent health programming significantly over the next few years.
9. WHO, UNFPA and UNICEF should synthesize information and give examples of the best practices for adolescent health programming; support research to identify cost-effective and sustainable approaches for expanding programming; and develop practical tools to assist programme development and implementation.
10. WHO, UNFPA and UNICEF should manage information needed for programme acceleration, including by use of new technologies such as CD-ROM and the Internet, and set up a system to monitor the status of adolescent health for possible eventual publication.

Regional actions to reinforce country efforts

11. WHO, UNFPA and UNICEF should cosponsor and support regional networks for training and for the exchange of ideas and information in adolescent health.
12. WHO, UNFPA and UNICEF should collect and analyse information on the health status of adolescents and on adolescent health programming at country level. They should also support operations research related to programming in order to draw out best practices.
13. WHO, UNFPA and UNICEF should encourage the sharing of knowledge by organizing and facilitating study visits by policymakers, religious leaders and programme managers to successful programmes, especially those that demonstrate the meaningful involvement of young people. These agencies should produce

programming guidelines, increase the dissemination and availability of successful programme resource materials and provide support for their adaptation.

14. WHO, UNFPA and UNICEF should build capacity and commitment by organizing interagency staff meetings to inform and mobilize personnel, extend consensus, identify priorities for action within and between agencies and facilitate access to regional resource persons.

12.2 Recommendations to countries

1. Countries should make the case for adolescent health by advocating the need for adolescent health policies and programmes, including those relating to sexual and reproductive health, on the basis of the public health and economic benefits which accrue from investing in the health and development of young people.
2. Countries should describe the needs in adolescent health and generate commitment to meeting them by cosponsoring situation analyses and planning activities, with the meaningful involvement of young people, such as creating multisectoral national task forces or convening national workshops, in order to forge coalitions with interested organizations and develop common plans of action.
3. Countries should build capacity by initiating collaborative training and sensitization of country nationals (including young people) to improve and sustain programming for adolescent health.
4. Countries should support the implementation of country action plans and other clearly focused activities in adolescent health, mobilizing local resources and building on existing infrastructures within the public, nongovernmental and private sectors.
5. Countries should support approaches that have the potential to be expanded in cost-effective and sustainable ways. In order to study the lessons learned, countries should carry out joint programme reviews, complementary to programming processes.
6. Countries should intensify the means used to share information that focuses on the health status of adolescents and successful programming experiences.
7. Countries should support the monitoring, evaluation and operations research of programmes, including the use of appropriate indicators, putting this information to use to inform the community and improve the quality and coverage of programmes.

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Barton T, Wamai G. *Indicators for adolescent health.*

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Brew-Graves SH. *Adolescent health in Ghana: a selected country study of school health services.*

Florenzano Urzua R. *Mental health interventions addressed to young people: a review.*

Hanson C. *Role of policy in the context of national adolescent health programs.*

Howard J. *Health sector interventions in reducing harmful use of tobacco, alcohol and other psychoactive substances.*

Khalakadina M. *Eastern Mediterranean regional report on adolescent health: a review and analysis of information on the health of female adolescents in the Eastern Mediterranean Region.*

Kusuma Buana Foundation. *South-east Asia regional report on adolescent health programmes — an overview of the adolescent health situation in SEARO regional countries: an input for the WHO Study Group on Programming for Adolescent Health.*

MacFarlane A, Peckham S. *Report to the World Health Organization on adolescent health in Europe survey.*

Monroy A. *Provision of counselling to adolescents in developing countries.*

Monroy A, Valesco L. *The quality and nature of counselling for adolescent sexuality and reproductive health in developing countries in Latin America and the Spanish Caribbean.*

Montsi MR. *The quality and nature of counselling in adolescent sexuality and reproductive health.*

Pan American Health Organization. *American regional report on adolescent health programmes: toward the development of a regional programme for addressing adolescent and youth health.*

Rasolofomanana R. *African regional report on adolescent health programmes — la programmation en santé des adolescents: revue de quelques expériences de la région africaine.*

Samarasinghe D. *Counselling for adolescents: Services in south and south-east Asia.*

Simon M, Monahan K, Slutkin G. *Selected studies of intentional injury/violence prevention and victim intervention.*

Sleet DA, Seay A. *Unintentional injury prevention in international settings.*

Wastell CA. *Effectiveness of counselling in adolescence.*

WHO Regional Office for the Western Pacific. *Western Pacific regional report on adolescent health programmes — case studies on adolescent health: Philippines, Malaysia, Republic of Korea and Australia.*

In addition, the following case studies were prepared for the Study Group's considerations:

Bunsanneh I. *Youth Front Against Drug and Alcohol Abuse*.

Dey D. *The Tata Iron and Steel Co. Ltd.: family initiatives and social services*.

Giridhar G. *Dehleez, radio serial drama. India: management and financial review of Dehleez. India — Prerana Associate CEDPA: management and financial review*.

Hickey P. *Botswana social marketing programme*.

Holzer M. *The Vistula Civic Foundation*.

Jamaica Red Cross and American Red Cross. *Jamaican Island-wide HIV/STD Prevention Project*.

Kaur J. *Newspaper-in-education: a model for dynamic education*.

Kaminsky DC. *Project alternatives, Tegucigalpa, Honduras*.

Katunzi NB. *UMATI — Family Planning Association of Tanzania*.

Lane C. *Nigeria and Ghana: the West African Youth Initiative*.

Maddaleno M, Gattini C. *Programming for adolescent health in Chile*.

Meshesha B. *Ethiopian Youth Project*.

Robinson G. *Management and financial review: Chile adolescent health programme. Trinidad and Tobago — Servol Limited: management and financial review*.

Serrano C. *Vietnamese Youth Union*.

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YWCA. *Peer approach to counselling by teens (PACT)*.

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Annex 1

Ottawa charter for health promotion¹

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Prerequisites for health

The fundamental conditions and resources for health are:

- peace
- shelter
- education
- food
- income
- a stable eco-system
- sustainable resources
- social justice
- equity

Improvement in health requires a secure foundation in these basic prerequisites.

Advocate

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through **advocacy** for health.

Enable

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status

¹ Source: *Health promotion*, 1986, 1:iii-v. Reproduced by permission.

and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

Mediate

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to **mediate** between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

Health promotion action means:

Build healthy public policy

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.

Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

Create supportive environments

Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and

their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance — to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment — particularly in areas of technology, work, energy production and urbanization — is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

Strengthen community action

Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities — their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

Develop personal skills

Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community

settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

Reorient health services

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

Moving into the future

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

Commitment to health promotion

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad

- nutrition; and to focus attention on public health issues such as pollution, occupational hazards, housing and settlements;
- to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
 - to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
 - to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
 - to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.

The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for international action

The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

The charter was adopted at an international conference on health promotion "The move towards a new public health", 17-21 November 1986, in Ottawa, Ontario, Canada. The conference was cosponsored by the Canadian Public Health Association, Health and Welfare Canada, and the World Health Organization.

Annex 2

Key articles from the United Nations Convention on the Rights of the Child

Considering that the aim is to protect/meet all rights for all children, the following rights are of particular importance in terms of young people's basic needs for health and development: information and life skills; access to services such as education, health, recreation and justice; a safe and supportive environment; and opportunities to participate.

Overarching rights

Article 1

For the purposes of the present Convention, a child means every human being below the age of eighteen years unless, under the law applicable to the child, majority is attained earlier.

Article 2

- 1. States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parent's or legal guardian's race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.*
- 2. States Parties shall take all appropriate measures to ensure that the child is protected against all forms of discrimination or punishment on the basis of the status, activities, expressed opinions, or beliefs of the child's parents, legal guardians, or family members.*

Article 3

- 1. In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.*

Article 6

- 1. States Parties recognize that every child has the inherent right to life.*
- 2. States Parties shall ensure to the maximum extent possible the survival and development of the child.*

Rights to information and skills

Article 17

States Parties recognize the important function performed by the mass media and shall ensure that the child has access to 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.

Article 29

1. *States Parties agree that the education of the child shall be directed to:*
 - (a) *The development of the child's personality, talents and mental and physical abilities to their fullest potential;*
 - (b) *The development of respect for human rights and fundamental freedoms, and for the principles enshrined in the Charter of the United Nations;*
 - (c) *The development of respect for the child's parents, his or her own cultural identity, language, and values, for the national values of the country in which the child is living, the country from which he or she may originate, and for civilizations different from his or her own.*
 - (d) *The preparation for the child for responsible life in a free society, in the spirit of understanding, peace, tolerance, equality of sexes, and friendship among all peoples, ethnic, national and religious groups and persons of indigenous origin.*
 - (e) *The development of respect for the natural environment.*

Rights to education and health services

Article 23

1. *States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.*
4. *States Parties shall promote, in the spirit of international cooperation, the exchange of appropriate information in the field of preventive health care and of medical, psychological and functional treatment of disabled children, including dissemination of and access to information concerning methods of rehabilitation, education and vocational services, with the aim of enabling States Parties to improve their capabilities and skills and to widen their experience in these areas. In this regard, particular account shall be taken of the needs of developing countries.*

Article 24

1. *States Parties recognize the right of the child to the enjoyment of the highest attainable standard of health and to facilities for the treatment of illness and rehabilitation of health. States Parties shall strive to ensure that no child is deprived of his or her right of access to such health care services.*
2. *States Parties shall pursue full implementation of this right and, in particular, shall take appropriate measures:*
 - (b) *To ensure the provision of necessary medical assistance and health care to all children with emphasis on the development of primary health care;*
 - (c) *To combat disease and malnutrition, including within the framework of primary health care, through, inter alia, the application of readily available technology and through the provision of adequate nutritious foods and clean drinking-water, taking into consideration the dangers and risks of environmental pollution;*
 - (d) *To ensure appropriate pre-natal and post-natal health care for mothers;*
 - (e) *To ensure that all segments of society, in particular parents and children, are informed, have access to education and are supported in the use of basic knowledge of child health and nutrition, the advantages of breast-feeding, hygiene and environmental sanitation and the prevention of accidents;*
 - (f) *To develop preventive health care, guidance for parents and family planning education and services.*

Article 28

1. *States Parties recognize the right of the child to education, and with a view to achieving this right progressively and on the basis of equal opportunity, they shall, in particular:*
 - (a) *Make primary education compulsory and available free to all;*
 - (b) *Encourage the development of different forms of secondary education, including general and vocational education, make them available and accessible to every child, and take appropriate measures such as the introduction of free education and offering financial assistance in case of need.*

Article 31

2. *States Parties shall respect and promote the right of the child to participate fully in cultural and artistic life and shall encourage the provision of appropriate and equal opportunities for cultural, artistic, recreational and leisure activity.*

Rights to a safe and supportive environment

Article 2

1. *States Parties shall respect and ensure the rights set forth in the present Convention to each child within their jurisdiction without discrimination of any kind, irrespective of the child's or his or her parents' or legal guardians' race, colour, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status.*

Article 3

1. *In all actions concerning children, whether undertaken by public or private social welfare institutions, courts of law, administrative authorities or legislative bodies, the best interests of the child shall be a primary consideration.*
2. *States Parties undertake to ensure the child such protection and care as is necessary for his or her well-being, taking into account the rights and duties of his or her parents, legal guardians, or other individuals legally responsible for him or her, and, to this end, shall take all appropriate legislative and administrative measures.*
3. *States Parties shall ensure that the institutions, services and facilities responsible for the care or protection of children shall conform with the standards established by competent authorities, particularly in the areas of safety, health, in the number and suitability of their staff, as well as competent supervision.*

Article 4

States Parties shall undertake all appropriate legislative, administrative, and other measures for the implementation of the rights recognized in the present Convention. With regard to economic, social and cultural rights, States Parties shall undertake such measures to the maximum extent of their available resources and, where needed, within the framework of international co-operation.

Article 5

States Parties shall respect the responsibilities, rights and duties of parents or, where applicable, the members of the extended family or community as provided for by local custom, legal guardians 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 present Convention.

Article 16

1. *No child shall be subjected to arbitrary or unlawful interference with his or her privacy, family, home or correspondence, nor to unlawful attacks on his or her honour and reputation.*
2. *The child has the right to the protection of the law against such interference or attacks.*

Article 18

1. *States Parties shall use their best efforts to ensure recognition of the principle that both parents have common responsibilities for the upbringing and development of the child. Parents or, as the case may be, legal guardians have the primary responsibility for the upbringing and development of the child. The best interests of the child will be their basic concern.*
2. *For the purpose of guaranteeing and promoting the rights set forth in the present Convention, States Parties shall render appropriate assistance to parents and legal guardians in the performance of their child-rearing responsibilities and shall ensure the development of institutions, facilities and services for the care of children.*

Article 19

1. *States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child*

Article 22

1. *States Parties shall take appropriate measures to ensure that a child who is seeking refugee status or who is considered a refugee in accordance with applicable international or domestic law and procedures shall, whether unaccompanied or accompanied by his or her parents or by any other person, receive appropriate protection and humanitarian assistance in the enjoyment of applicable rights set forth in the present Convention and in other international human rights or humanitarian instruments to which the said States are Parties.*

Article 24

3. *States Parties shall take all effective and appropriate measures with a view to abolishing traditional practices prejudicial to the health of children.*

Article 25

1. *States Parties recognize the right of a child who has been placed by the competent authorities for the purposes of care, protection or treatment of his or her physical or mental health, to a periodic review of the treatment provided to the child and all other circumstances relevant to his or her placement.*

Article 27

1. *States Parties recognize the right of every child to a standard of living adequate for the child's physical, mental, spiritual, moral and social development.*
3. *States Parties, in accordance with national conditions and within their means, shall take appropriate measures to assist parents and others responsible for the child to implement this right and shall in case of need provide material assistance and support programmes, particularly with regard to nutrition, clothing and housing.*

Article 32

1. *States Parties recognize the right of the child to be protected from economic exploitation and from performing any work that is likely to be hazardous or to interfere with the child's education, or to be harmful to the child's health or physical, mental, spiritual, moral or social development.*

Article 33

States Parties shall take all appropriate measures, including legislative, administrative, social and educational measures, to protect children from the illicit use of narcotic drugs and psychotropic substances as defined in the relevant international treaties, and to prevent the use of children in the illicit production and trafficking of such substances.

Article 34

States Parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes, States Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

- (a) The inducement or coercion of a child to engage in any unlawful sexual activity;*
- (b) The exploitative use of children in prostitution or other unlawful sexual practices;*
- (c) The exploitative use of children in pornographic performances and materials.*

Article 35

States Parties shall take all appropriate national, bilateral and multilateral measures to prevent the abduction of, the sale of or traffic in children for any purpose or in any form.

Article 36

States Parties shall protect the child against all other forms of exploitation prejudicial to any aspects of the child's welfare.

Article 38

- 2. States Parties shall take all feasible measures to ensure that persons who have not attained the age of fifteen years do not take a direct part in hostilities.*

Rights to participation

Article 12

- 1. States Parties shall assure to the child who is capable of forming his or her own views the right to express those views freely in all matters affecting the child, the views of the child being given due weight in accordance with the age and maturity of the child.*
- 2. For this purpose, the child shall in particular be provided the opportunity to be heard in any judicial and administrative proceedings affecting the child, either directly, or through a representative or an appropriate body, in a manner consistent with the procedural rules of national law.*

Article 13

- 1. The child shall have the right to freedom of expression; this right shall include freedom to seek, receive, and impart information and ideas of all kinds, regardless of frontiers, either orally, in writing or in print, in the form of art, or through any other media of the child's choice.*

Article 14

- 1. States Parties shall respect the right of the child to freedom of thought, conscience and religion.*
- 2. States Parties shall respect the rights and duties of the parents and, when applicable, legal guardians, to provide direction to the child in the exercise of his or her right in a manner consistent with the evolving capacities of the child.*

Article 15

1. *States Parties recognize the rights of the child to freedom of association and to freedom of peaceful assembly.*

Article 23

1. *States Parties recognize that a mentally or physically disabled child should enjoy a full and decent life, in conditions which ensure dignity, promote self-reliance and facilitate the child's active participation in the community.*

Putting it all together: combining interventions in different settings

Programmes and projects for adolescents, as for any population group, need to consider issues of “what”, “for whom”, and “delivered where”. “What” entails what is to be delivered, (i.e. what information, what skills, what type of services). The “to whom” element requires considering segmentation of populations, such as at different ages and by social groupings (e.g. gang members, street children, males, females, etc.). The “where” issue is the question that defines delivery for most persons.

For operational purposes, successful experiences in programming for adolescents can be categorized as:

- family and home-based;
- school-based;
- health service-based;
- community-based;
- worksite-based.

Successful experiences in adolescent health have combined more than one intervention such as providing information, skills training, counselling and health services as well as addressing issues in the social environment that threaten health and well-being. Many successful experiences seem to have combined approaches to more than one risk behaviour, while some have also focused on more central and developmental needs. Although many have not approached the issues so comprehensively, it is apparent that opportunities exist for doing so. Further, the successful experiences also provide the opportunity to see that prevention and care go hand in hand and sometimes cannot be separated.

The examples of successful experiences noted below have been selected because there is good reason to consider them a success, in particular because of the demonstration of results, or change in one or more programme areas. There is sufficient information on the methods of delivery and there is reason to believe that these can be delivered to scale and are feasible in other settings because of current coverage, duration, or successful expansion.

1. **Family and home-based interventions**

1.1 ***Possible target population groups***

Early childhood, adolescents, parents including adolescent parents.

1.2 **Rationale**

Interventions consist of skills training for children and parents, psychosocial support for parents, and family therapy through counseling. The home is often the only place where some particularly isolated mothers and children can be reached, and many problems exist or begin there. In addition, more than one age group can be reached simultaneously. It might be possible to overcome major communications issues. The home is a good point for diagnosis. It provides an opportunity for involvement of the extended family and for help where extended family or family support is not available (e.g. in cases recent migration to urban centres).

1.3 **Discussion**

There is little experience in such formalized intervention in developing countries. It may be that support is provided through extended family relationships and activities. However, the gap is clear where there is rapid urbanization. For example, many children and adolescents on the street cite family violence as a main reason for their leaving home.

1.4 **Possible accomplishments**

Reduction of child abuse through home visits

Example: home visitation

Many of the most pervasive and costly problems faced by high-risk women and young children in society are a consequence of adverse maternal health-related behaviour (cigarette smoking, drinking, and drug use during pregnancy), dysfunctional infant care-giving, and stressful environmental conditions that interfere with individual and family functioning. These problems include low birth weight, child abuse and neglect, childhood injuries, unintended and closely spaced pregnancy, and reduced economic self-sufficiency on the part of the parents. Evidence is accumulating that these problems can be reduced with comprehensive programmes of prenatal and infancy home visitation by nurses. Home visitation is a promising strategy, but only when it includes: a focus on families at greater need of the service; the programming of nurses' visits to begin during a woman's pregnancy and continue at least throughout the second year of the child's life; the promotion of positive health-related behaviour and qualities of infant care giving; and provisions to reduce family stress by improving the social and physical environment in which families live. Interventions provided include information provision and skills building and counselling.

In one evaluation (1) of interventions provided to adolescent and/or single mothers of low socioeconomic status through home visitation, the intervention group, compared to the control group:

- had greater awareness of community services;
- attended childbirth classes more frequently;
- indicated that their babies' fathers showed more interest in their babies;
- had fewer kidney infections;
- improved their diets more;
- decreased the amount they smoked more;
- had infants that weighed more;
- had longer gestation periods;
- abused their children less;
- reported that their infants had more positive moods;
- made fewer visits to the emergency room;
- obtained employment more often;
- had fewer subsequent pregnancies.

These findings translated into specific results of:

- reduction in child abuse (80%);
- fewer visits for emergency hospital care (38%);
- fewer visits to the physician for injuries or ingestions of noxious substances (87%);
- increase in the number of months the home-visited mothers were employed (82);
- 395 grams more in the average weight of neonates;
- reduction in preterm delivery (75%).

Increases in subsequent school completion and employment and fewer arrests

Example: home visitation and preschool education

The Perry Preschool Programme (2) in the USA was aimed at 3–4-year-old African-American children of low socioeconomic status and low intellectual performance who were assessed to be at high risk of school failure. Half of the children were from single parent families and all of the children's parents had low intelligence quotient scores, low education levels, and poor employment records.

The programme was based on "head start" programmes, the goal of which is to enhance the development of knowledge, thinking and social skills, and disposition to learning among the participating children. The programme included daily two and a half hour classroom sessions for children on weekday mornings as well as a weekly one and a half hour home visit to each mother and child on weekday

afternoons. Interventions centred on skills training, support and counselling. Important features of this programme included: developmentally appropriate active learning curricula; low staff to child ratio — 1:10; staff considering parents as partners and working closely with them in the class and home (monthly visits were made) to learn from them and help them to keep in touch with and understand the pre-school curriculum and their children's development; and programme administrators providing in-service training and supervisory support for their staff.

Evaluation of the participating childrens' progress over 20 years indicates:

- 40% fewer arrests by age 19;
- 35% increase in high school graduation;
- 55% increase in employment;
- 50% fewer pregnancies during adolescence than control group;
- by age 27, one in three of the control group had been arrested five or more times compared with one in 14 of the Perry Preschool children.

Reductions in subsequent arrests following home and family therapy

Example: multisystemic therapy to adolescents and families

Adolescents considered to be at imminent risk of incarceration and their families were provided intensive counselling by trained counsellors each with a caseload of four families. The counsellors were also available on a 24-hour basis to the families. Multisystemic therapy is based on a consideration of the reciprocity of interpersonal relations and posits that adolescent behaviour problems typically reflect dysfunctional family relations. Counselling addressed psychological, social, educational, and material needs of all of the families' members with the overall aim of preserving the family unit.

In one study, multisystemic therapy delivered through a community mental health centre was compared to violence prevention services delivered through Department of Youth services. The average treatment time was 13.4 weeks and there was a follow-up after 59 weeks (3). Results indicated:

- Self-reported offences of adolescents in receipt of Department of Youth services were greater than those of adolescents benefitting from multisystemic therapy (8.6 vs. 2.9).
- Arrests of adolescents receiving Department of Youth services were greater than those of adolescents receiving multisystemic therapy (1.52 vs. 0.87).

- Fifty-eight per cent of adolescents receiving multisystemic therapy were not rearrested whereas only 38% of those receiving Department of Youth services were not rearrested.
- Time in out-of-home placements was greater for those receiving Department of Youth services than for those undergoing multisystemic therapy (16.2 weeks vs. 5.8).
- Adolescents who received multisystemic therapy spent an average of 10 weeks fewer incarcerated.
- Eighty per cent of those in multisystemic therapy were not incarcerated, and only 32% of those receiving Department of Youth services were not incarcerated.
- The four-year recidivism rate for adolescents in multisystemic therapy was 22% as compared to 72% for those receiving Department of Youth services.
- Costs of department of youth services were US\$ 16300 compared to US\$ 2800 for multisystemic therapy.

2. **School-based interventions**

2.1 **Possible target population groups**

School-aged children, adolescents.

2.2 **Rationale**

Increasing numbers of children are attending school throughout the world, and school provides a convenient location for intervention delivery (although in some countries there are major differences between males and females in school attendance, the actual level of school completion and discontinuation of schooling during adolescence). The structured nature of school curricula provides opportunities for the inclusion of developmentally appropriate provision of information and skills training. The optimal delivery of skills-based education can also benefit teachers with regard to their knowledge about health issues and their teaching skills. The school setting also provides opportunities for peer approaches.

2.3 **Possible accomplishments**

Reduced pregnancy during adolescence through a combined programme to reduce pregnancy and STD/HIV infection

Example: peer education to adolescents in school

The Peer Approach to Counselling by Teens (PACT) programme in Botswana aims to reach 13–19-year-olds both in and out of schools with the provision of information, skills building and counselling. The purpose of the programme is to enable youth to make healthy decisions about their own sexuality, to avoid unwanted pregnancy and

infection with HIV/STDs, and especially to enhance their own confidence and self-esteem. Another important aim of the programme is to build understanding and gain support from the education and health authorities, schools, parents, and the community.

Ten adolescents were selected and trained in each school to conduct sessions to increase their peers' knowledge about human sexuality and reproductive health, develop their capacity to assess the social environment that could compromise their health and development, increase their abilities to communicate with adults and peers regarding behaviour that increases their risk of pregnancy and HIV/STDs. Other means of providing information to adolescents included drama, songs, discussion groups, poster contests, public debates, and information booths at fairs and church events.

This programme is an example of effective direct involvement of the target group. The success of the intervention is dependent on the action of the young people themselves. The motivation of the students is evidenced not only by their readiness to work during their school holidays, but also by their other initiatives. Peer educators are directly involved in designing and implementing the educational activities of the programme and have played an active role in developing peer educator curricula and guides, and brochures. Peer educator activities have not only influenced the participants' peers in school, but families and community members as well.

Evaluation of the programme (YWCA, unpublished data, 1995) indicated a reduction in the numbers of students leaving school due to pregnancy in those schools where PACT activities were strong. The programme, initiated and operated by a youth NGO (YWCA of Botswana), has also won wide acclaim from the community, government and international donors for increasing attention to the health of adolescents.

3. Health service-based interventions

3.1 Possible target population groups

Children, adolescents and adults.

3.2 Rationale

Diagnostic and treatment services for specific health problems as well as the provision of information regarding health behaviour can be provided efficiently at service points. For some population groups, especially adolescents who tend not to use health services, features of service delivery are important — assessment, confidentiality, flexibility in site and provider knowledge and skills.

3.3 **Possible accomplishments**

Reductions in HIV infection and STDs

Example: treatment of STDs among sexually active adolescents and adults

The programme in the United Republic of Tanzania consisted of the establishment of an STD reference clinic and laboratory, staff training in the diagnosis and treatment of STDs with syndromic treatment algorithms, and provision of health education, free condoms and a regular supply of drugs. A special delivery system was established, as well as regular supervisory visits to health facilities by a programme officer to provide in-service training, and periodic visits by a team of health educators to the villages served by each health facility to provide information on STDs. Given that the HIV epidemic and the rates of STD incidence in the developing world are increasing and the treatment of STDs is poor, this intervention trial provided an important model demonstrating the importance of complementing educational interventions aimed at modifying risky behaviour through improvements in STD treatment services.

The results of the trial showed an overall reduction of 42% in HIV incidence over the two-year follow-up period among adolescents of both sexes, and the reduction was consistently evident in all matched pairs of study communities. At the two-year follow-up, prevalence of active syphilis was 10.4% in the intervention group and 11.4% in the comparison group. Patient registers indicate that only 0.9% of the patients took condoms. Surveys regarding behavioural change were conducted at baseline and follow-up, and these data indicate no change in sexual behaviour over this two-year period. Thus, in the absence of sexual behaviour change, the most plausible explanation for the decrease in the incidence of HIV is that the intervention shortened the average duration of STDs, thereby effectively reducing the probability of HIV transmission.

4. **Community-based interventions**

4.1 **Possible target population groups**

Many.

4.2 **Rationale**

The diverse, multidisciplinary nature of these settings provides considerable flexibility to meet the needs of adolescents. Innovation in intervention delivery is a common feature. However, coverage is frequently limited and sustainability uncertain.

4.3 **Possible accomplishments**

Comprehensive programming for adolescent development and reduction in risky behaviour including unsafe sex and substance abuse

Example: adolescent development programme

This programme for adolescents in Trinidad is part of efforts by SERVOL (4) to bring community members together to address common needs so that eventually whole communities gain confidence in their abilities to achieve. Self-development is the key to this approach. This means that principles are used to empower the communities to develop at their own pace, in accordance with their own needs, and at the level that they can afford. Forty life centres have been founded where adolescents gain a sense of support and structure from staff members and fellow participants. In most centres, six to twelve adolescents (ages 16–19) participate in the three and a half month, five-day a week, eight-hour per day programme where they take literacy courses, and learn self-awareness and self-esteem. Information and skills training related to the use of substances, sexuality and prevention of health problems associated with sexual behaviour are offered. Six to eight months are then spent focusing on vocational skills related to specific trades. Both adolescent girls and boys learn basic knowledge about child developmental, nutrition and parenting skills. The programme costs nine dollars per month, and a total of 3000 adolescents benefit from it each year.

Important lessons have been learned from the over 20 years of experience of SERVOL. The flexibility and adaptability of the programmes to the needs of the communities in which they operate through minimal involvement by government officials have served parents, adolescents, and children through active and receptive listening. Unemployment among adolescents in communities with centres has been reduced to an overall 24% (47% unemployment of 15–19-year-olds and 38% of 20–24-year-olds); 10% of the adolescents in the programme return to finish secondary school. Seventy-five per cent find jobs. SERVOL's dropout rate is 5% (compared to the 40% dropout rate in the Youth Training Employment Partnership Programme launched by the government in 1988).

Reductions in violent behaviour at bars and in neighbourhoods

Example: Julakari/Aboriginal Night Patrol

The community of Tennant Creek, an Aboriginal community in Australia, is a geographically and socially isolated town in which excessive alcohol intake is the common form of social relaxation. One study found that the proportion of expenditure on alcohol ranged from 27%

to 55% in some Aboriginal communities, compared with 6.37% for non-Aboriginal Australians. Problems associated with alcohol use (by both adolescents and adults) include fighting and the consequent physical and social trauma. The programme consists of community “patrols” of volunteer community elders (usually women) who work in conjunction with the local police to convey people who are intoxicated and causing disturbances to a shelter where they undergo detoxification. They do not come into contact with the police. Each morning, a community meeting is held to mediate disputes and warn the offender. The “punishment” is usually a verbal “dressing down”. This is usually embarrassing enough to deter repeat offending. An important adjunct of these community meetings has been the informal institution of community rules defining unacceptable behaviour. In addition, from 1990 to 1992, alcohol-related crime decreased by 43% (from 352 to 201 cases). Intoxicated individuals are increasingly entering the shelter on a voluntary basis.

5. **Worksite-based interventions**

5.1 **Possible target population group**

Those working in particular sites.

5.2 **Rationale**

The needs of adolescents (and adults) to survive economically often endangers their health and development, due to the types of work they engage in and/or the physical and social environment of the work.

5.3 **Possible accomplishments**

Substantial reductions in HIV/STD

Example: promotion of condom use among commercial sex workers

Those most vulnerable to HIV infection in Thailand are considered to be female sex workers (there are over 100 000) and their male clients. Pilot projects to enforce 100% condom use were introduced through intensive provision of information and the availability of condoms. In each area in which these projects were introduced, the owners of sex establishments and sex workers were informed of the project and its benefits, and were assured that its implementation would not affect their income. If the owners were non-compliant, they risked being fined and being forced to close down their businesses.

In 1990, average condom utilization rate among female sex workers was between 60% and 70%, and that of STD clinic client visits was under 50%. In two provinces of Thailand, Samut Sakhon and

Pitsanuloke, the number of condoms used by sex workers increased from fewer than 15 000 per month to more than 50 000 per month after the project's initiation. The monthly incidence of STDs among sex workers decreased from 13% before the project began to 0.3%–0.5% after implementation. Sixty-six of Thailand's 73 provinces were reported to be in the process of implementing similar projects (5).

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