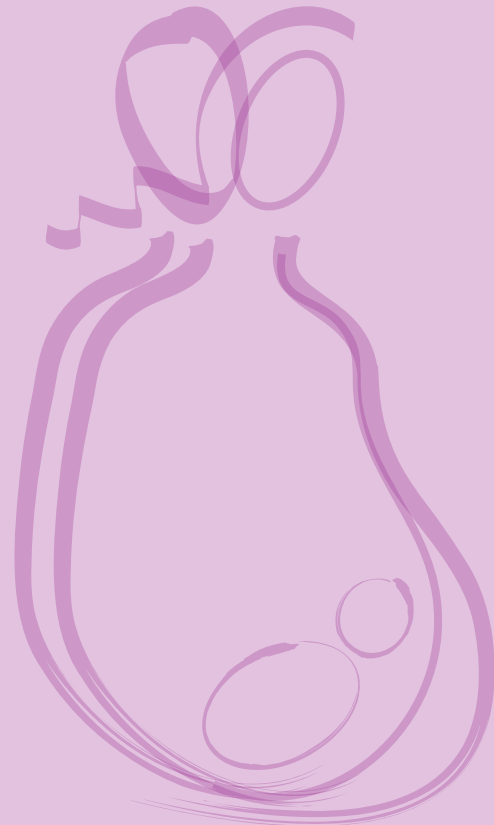




**World Health
Organization**

Report of the expert group meeting on mainstreaming adolescent pregnancy in the work of the World Health Organization

Department of Making Pregnancy Safer







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**10 - 12 February 2009
WHO, Geneva**

Department of Making Pregnancy Safer

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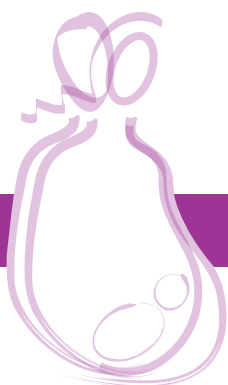
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Acronymns

ADH	Adolescent health and development
AFHS	Adolescent-friendly health services
CAH	Child and Adolescent Health Department, WHO
CEDAW	Convention on the Elimination of all Forms of Discrimination against Women
CRC	Conventions on the Rights of the Child
DHS	Demographic and Health Survey
GWH	Gender, Women, and Health Department, WHO
HIV	Human immunodeficiency virus
ICPD	International Conference on Population and Development
IMPAC	Integrated management of pregnancy and childbirth
INGO	International nongovernmental organization
MDGs	Millennium Development Goals
MPS	Making Pregnancy Safer Department, WHO
NGO	Nongovernmental organization
RH	Reproductive health
RHR	Reproductive Health and Research Department, WHO
STI	Sexually transmitted infection
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization



1. Introduction and background

From 10 to 12 February 2009, the World Health Organization's Making Pregnancy Safer (MPS) Department, in collaboration with the Department of Child and Adolescent Health and Development (CAH) and the Department of Reproductive Health and Research (RHR), held a three-day expert group meeting on the subject of adolescent pregnancy.

The overall aim for the meeting was to achieve consensus from international experts and WHO staff on the optimal ways to address issues arising from pregnancy in adolescence within the work of the key departments of WHO. More specifically, the meeting aimed to review the adequacy of the evidence and information presented in the document entitled "Position Paper on Mainstreaming Adolescent Pregnancy in the WHO's Making Pregnancy Safer Strategic Approach" (World Health Organization, 2008), as well as to examine key actions that could advance WHO's work in addressing adolescent pregnancy at all levels within the Organisation.

There were two parts to the meeting - the first day and a half were dedicated to reviewing the Position Paper and were centred around presentations and small group discussions on the paper's various components. This included a review of the Position Paper's overall framework and context for examining adolescent pregnancy, in addition to the three areas of 1) health and other impacts of adolescent pregnancy; 2) determinants of and access to pregnancy care, and finally 3) adolescent-specific interventions for pregnancy care. The latter half of the meeting then used the evidence review as a springboard to examine existing work in the area of adolescent pregnancy and to focus on the identification and delineation of key actions for advancing WHO's work in this area at the Headquarters, Regional Office and country level.

The expert group meeting made deliberate efforts to build on existing work in the area of adolescent pregnancy, including the technical working group meeting on "Meeting the Millennium Development Goals for Maternal Mortality Reduction and Pregnant Adolescents," convened by WHO and held in Geneva August 5-6, 2003. It also drew on previous literature reviews on adolescent pregnancy including previous WHO-commissioned reviews (World Health Organization, 2004; World Health Organization, 2007), which was used as the basis of the Position Paper. The outcomes of this meeting are equally to align closely with the work in progress of various WHO departments, including the planned Systematic Review of Interventions to Prevent Too Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries, led by the CAH Department.

2. Objectives

Within the overall aim to build consensus from international experts and WHO staff on the optimal ways to address adolescent pregnancy issues within the work of the WHO, three specific objectives guided the structure and process of the expert group meeting.

These were:

- To review the adequacy of the evidence on adolescent pregnancy presented in the Position Paper as the basis for advocacy and country level programmatic responses.
- To review existing work, identify and prioritize key actions for WHO's support to Member States for addressing adolescent pregnancy in the context of achieving Millennium Development Goals (MDGs) 4 and 5.
- To delineate how to implement key actions at the regional and country level.

3. Participants

There were approximately 45 participants in attendance throughout the meeting (See Appendix A: List of Participants).

The composition of participants reflects in part the dual objectives of the consultation. To achieve the consultation's objective of reviewing the evidence on health impact and effective programming required a range of research and program expertise, from both within and outside of WHO. Likewise, to adequately achieve the objective of developing an internally focused WHO action plan required the presence of broad range of headquarters and regional staff. For the sake of continuity, there was some crossover representation of participants from the August 2003 technical working group.

Roughly a third of the participants to the meeting were experts from international research, academic, and professional organizations. This included the authors of the current and previous in-depth reviews carried out on adolescent pregnancy. A quarter of the participants were from partner organizations, such as UN agencies and bilateral donors. The remaining participants were composed of staff within various departments of the WHO. From Regional Offices, this included staff responsible for MPS and Adolescent Health and Development for five of six WHO regions (the one exception of the Regional Office for the Americas, which was unable to attend). From WHO Headquarters, staff members from the Departments of Making Pregnancy Safer (MPS), Child Health and Adolescent Development (CAH), Reproductive Health and Research (RHR), and Gender, Women and Health (GWH) were actively involved in the meeting.

4. Methodology, agenda and coordination

To maximize the contribution from the assembled experts, partners, and WHO staff, the meeting incorporated a range of methods that included plenary sessions, facilitated panel discussions, and a significant number of guided small working group discussions (See Appendix B: The Meeting Agenda).

For the review of the Position Paper, this was structured as follows: For each of the main sections, the paper's author, Mr. James Rosen, Consultant to WHO, presented an overview of the findings and provided lead questions to guide the review of evidence (See Appendix C: List of Presentations). The key questions aimed to frame the discussion in terms of what *new* has been learned since the previous technical consultation in 2003. This was followed by remarks from a lead discussant and an opportunity to clarify any questions or considerations regarding the presentations. From there, participants worked in small discussion groups to review specific questions concerning the existing evidence and what more may be needed, both in terms of completing the Position Paper and within the context of larger data and informational needs. Each working group had an assigned rapporteur, who captured the discussions and briefly reported to the larger group in plenary. This format was used throughout the first day and a half, for each of the main areas within the position paper, namely health and other impacts of adolescent pregnancy, determinants of and access to pregnancy care, and adolescent-specific interventions for pregnancy care.

After presentation and discussion on the findings of the Position Paper, Dr. Dina Khan, author of the previous 2003 in-depth review on adolescent pregnancy, and Dr. Shyam Thapa representing the RHR department, gave synthesis presentations. This marked a shift in the meeting's focus, from centring on reviewing evidence and information, to concentrating on reviewing existing work and delineating key actions to advance WHO work on adolescent pregnancy. To initiate this transition to action-oriented planning, a panel discussion on the perspectives and responses from partner agencies was held over the lunchtime session on the second day. This was followed by a series of presentations from regional representatives on how WHO is currently addressing adolescent pregnancy in regions and countries.

To discuss the implications of the evidence presented in the Position Paper and other technical inputs, a series of small group sessions were held on the second and last day of the meeting, both in terms of regional and stakeholder groupings. In regional groups, participants reviewed priority needs in countries

and current WHO actions. Participants further examined these actions in terms of strengths and weaknesses and prioritized them. They used the priority actions to guide the identification of what support may be presently absent or inadequate in terms of addressing the issues of adolescent pregnancy in the regions. In the various stakeholder groups (e.g. researchers, Ministries of Health or service providers, partners and agencies and WHO), participants reviewed some of the actions required to advance and mainstream the prevention and care of adolescent pregnancy from their unique stakeholder perspective.

By the closing session of the meeting, each group was in a position to present a synopsis of their small working group discussions and recorded inputs to Ms. Daisy Mafubelu, Assistant Director-General, Family and Community Health cluster. To guide the overall process of small group work, participants were given handouts throughout the meeting with detailed instructions, as well as electronic versions of the pre-formatted charts for the group rapporteur to record and submit inputs (See Appendix D: Participant Handbook and other Handouts). Furthermore, to ensure that participants had access to the relevant background documentation, particularly the 2 previous WHO literature reviews and the latest literature summarized in the Position Paper, a resource binder and CD was distributed to everyone at the beginning of the meeting (See Appendix E: List of Documentation for CD).

The organization and design of the meeting was the result of collaborative planning between WHO departments of CAH, RHR, and GWH. Although the MPS Department took the lead on providing technical direction and logistics coordination, there was shared input on the agenda, participants, structure, and materials.

5. Summary of output from the meeting sessions

5.1 Welcome and introductions

The meeting began with welcoming remarks from the three Departments directly involved in the organization of the meeting. Dr. Elizabeth Mason, Director of the Department of Child and Adolescent Health and Development, noted the crosscutting nature of adolescent pregnancy and the need to address it in a holistic way. In this regard, adolescent pregnancy was noted to be a topic that could guide the harmonization of efforts to respond to the needs of adolescents and for working collaboratively across departments within WHO.

Dr. Shyam Thapa spoke on behalf of the Department of Reproductive Health and Research and noted the challenges to collecting data adolescents' sexual and reproductive health. He informed that RHR has supported more than 50 studies in this area. Dr. Thapa noted the department's continued efforts to collaborate toward building a strong body of evidence to support effective interventions in this area.

Dr. Viviana Mangiaterra spoke on behalf of the Making Pregnancy Safer Department and took the opportunity to explain some of the reasons behind the meeting. To begin, there is a need to respond to the increasing number of requests from regions and countries for support on the issue of adolescent pregnancy. Additionally, MDG 4, to reduce child mortality and MDG 5, to improve maternal health, are gaining increasing attention in international efforts to achieve the MDGs. Therefore, the meeting can be seen as an opportunity to review how WHO responds to these growing needs and to guide staff at the country level in support of Member States.

She also clarified that this meeting is one of several steps in the process of strengthening WHO's response to adolescent pregnancy. A first step was to commission the Position Paper, itself based on previous work, and to review what the evidence tells us to date. She clarified that the Position Paper is not meant to be a systematic review, but rather a stocktaking and update of existing evidence in order to provide some direction and a coherent framework for action on adolescent pregnancy.

Following these remarks, Ms. Julie Larsen, workshop facilitator and rapporteur, gave a brief overview of the meeting process and agenda of the meeting and facilitated an introduction of all participants.

5.2 Position paper's overview of adolescent pregnancy

In the first of a series of presentations on the Position Paper, Mr. Jim Rosen provided an overview of the scope and context for adolescent pregnancy used throughout the paper. This included introducing a conceptual framework, presenting the scope of adolescent pregnancy in terms of absolute numbers, regional variations and trends, and examining the context and contributing factors to adolescent pregnancy (See Appendix F: Slides from Presentation – Overview of Adolescent Pregnancy by Jim Rosen).

The presentation was followed by lead discussant remarks prepared by Dr. Virginia Camacho of CAH. She focused not only on what current information tells us of adolescent pregnancy, but placed particular emphasis on what else we need to know to formulate effective policies. She equally challenged the group to look “beyond the numbers” to better understand the context surrounding adolescence pregnancy (See Appendix G: Slides from Presentation – Lead Discussant Remarks – Vicky Camacho).

Following these presentations, a plenary discussion ensued to receive general questions and comments on the scope and context for adolescent pregnancy used in the Position Paper. Some of the feedback received included the following points:

General comments on the structure and approach of the paper

- Some of the paper's figures and charts mix two separate factors or distributions – this makes it hard to interpret and analyse the data and should be avoided if possible.
- It would be useful for the paper to include a brief summary of the MPS strategic approach, to put the papers findings into context.
- In general, the paper needs to be clear in its usage of terms and differentiate between various concepts (e.g. fertility and fertility rate should not be used interchangeably). A glossary of terms would be extremely useful.
- Using Demographic and Health Survey (DHS) data needs to be qualified and often requires triangulation with other sources of data.

Specific comments regarding the scope and context of adolescent pregnancy

- In the conceptual framework, several terms appear in quotes e.g. “wanted” pregnancy. This is generally understood to denote a nuanced approach to these concepts, but as policy makers and practitioners, we need to be especially attuned to when pregnancies are “planned” versus “unplanned” and “wanted” versus “unwanted.” Who decides when we use the inverted commas? The paper should propose clear definitions, in line with the 1994 International Conference on Population and Development's (ICPD) demarcation of reproductive health rights.
- In terms of possible explanations for the observed decline in adolescent birth rates, it could be interesting to do a correlation to factors such as condom use, abortion rate, increased age of marriage or increased awareness and access to contraceptives.
- It may be useful to incorporate a human rights based approach, particularly in the context of the Conventions on the Rights of the Child (CRC), positioning adolescents pregnancy as child pregnancy, “a child giving birth to a child”. This could have important implications for policy-making and legislation.
- The paper should recognize that delay in age of marriage is very culturally specific and can vary greatly within countries, districts, and even communities..
- Any abortion data presented in the paper needs to qualify that abortion is under-reported and as such cannot be used to predict trends with any certainty.
- The paper needs to address the issue of violence and trafficking of adolescent women.
- There needs to be a short paragraph on the role of fathers, partners, men in the family as all have considerable impact on the development of interventions.

- The paper needs to more carefully examine the issue of repeat pregnancy among adolescents.
- The paper could be strengthened by strong recommendations for policy makers and practitioners that challenge norms and suggest new approaches and services.
- The paper should give greater attention to how legal and policy frameworks might bear upon defining adolescents, and influencing their use of care.
- There could be greater inclusion and analysis on socio-economic determinants of adolescent pregnancy.

5.3 Position paper's approach to health and other impacts of adolescents pregnancy

The next section of the Position Paper that was reviewed concerned the health and other impacts of adolescent pregnancy. Mr. Jim Rosen presented an overview of the findings from the literature that looked more closely at the underlying behaviours and health problems associated with adverse pregnancy outcomes in relation to risks for adolescents versus older women. He also reviewed the results from several studies on health behaviours and health problems that influence maternal and newborn health outcomes (See Appendix H: Slides– Health and other Impacts of Adolescent Pregnancy by Jim Rosen).

Following the overview presentation, Dr. Lale Saye of RHR provided discussant remarks. She pointed out that in terms of adolescent mothers and their newborns being at greater health risk than older women, the evidence seems to indicate that this is particularly the case among the younger adolescents, below age 16. Above the age of 16, there is less certainty that adolescent pregnancy carries greater risk. She also noted that factors such as unsafe abortions and higher rates of suicide in young mothers raise risks in adolescent mothers. In terms of improving the Position Paper, she suggested it would be useful to apply a quality filter to the evidence gathered to date and undertake a more detailed analysis of those studies for which good results exist (i.e. include a summary table that present the studies sample size, methodology used, adjustments and control factors, etc.). It is data from the high quality studies that the paper should then present in detail.

A brief discussion was held in plenary and participants raised the following general points: There needs to be careful review and statement made on the quality of the data, particularly for non-adjusted studies.

- Questions were raised regarding confounders and which of these have been adjusted and the resulting influence the data.
- Much of the paper's examination of impacts is based on quantitative data and should be balanced with qualitative data and possibly some interesting community-based data. This could expose complementary areas for interventions.
- The limitations of the paper should be clearly highlighted throughout the document. The paper should also explain the implications and limitations of using DHS data.
- Stratification of the data by income quintile, place of residence and regional variations would be useful if possible.
- In general, participants flagged additional material and studies that are available and these can be used to strengthen the ongoing development of key findings and messages.
- Overall, there is a need to produce evidence and initiate studies that simply do not exist. This meeting (e.g. the result of the small group discussions on the adequacy of the evidence) is a source of guidance as to what research that might be. It is also important to note that the WHO's standards as to what constitutes a systematic review are very high. While this type of quality research is being amassed, there must still be advancement in the area of adolescent pregnancy. For now, this may have to be based on weak evidence, as countries are moving ahead in their attempts to respond to the needs in this area.

From here, participants assembled into smaller working groups to discuss specific questions related to the available data on the health and other impacts of adolescent pregnancy (see Appendix D for matrices used in the group work). Participants had mixed views on the adequacy of the evidence to support the Position Paper's contention of the existence of an independent effect of early maternal age on maternal health problems, even after controlling for factors such as giving birth for the first time, socioeconomic differences, and access to prenatal care. By contrast, participants were confident in endorsing the Position Paper's assertion that the evidence is clear that childbearing before 16 carries inherently higher health risks for mothers and that these health risks appear to decrease gradually as adolescent childbearing age increases. Participants noted the relatively few studies that adjust for possible confounding factors and the overwhelming reliance on hospital-based rather than community-based studies. Participants further noted the need to explore links between socioeconomic context and pregnancy outcomes, and the need for examining region and—if possible—country-specific health impacts.

Regarding the evidence on which specific maternal health problems appear to be more pronounced among adolescents compared with older mothers, participants raised some of the same concerns regarding quantity, quality, and social and geographic diversity of the data sources. The Position Paper's findings that evidence is still lacking for an independent age effect on the likelihood of obstetric fistula led to a discussion in which diverse opinions were put forth. Participants recognized the need for greater age disaggregation of fistula data, distinguishing between the incidence of fistula and access to services, and examining the role of family and community attitudes toward fistula.

Participants were supportive of the Position Paper's assertion regarding the impact of adolescent pregnancy on newborn health, which states that the evidence is fairly strong of an independent effect of early maternal age on newborn health problems, even after controlling for factors such as giving birth for the first time, socioeconomic differences, and access to prenatal care. The negative impacts on newborn health appear to be present for older as well as younger adolescents, with the risk increasing as mother's age decreases.

The Position Paper also asserts that early childbearing may independently raise the risk of other health problems including mother's premature death later in life, mental illness, obesity, etc. Participants noted the need for more and higher quality studies to further examine these impacts.

With respect to the social and economic impacts of adolescent pregnancy, the Position Paper contends that, although numerous studies have shown an association between adolescent pregnancy and negative social and economic effects on both the mother and her child, the evidence is still inconclusive about whether adolescent pregnancy is the cause or consequence of adverse socioeconomic outcomes for the individual. Participants recognized the methodological limitations of the literature on this question, and recommended further analysis to better answer this question.

5.4 Position paper review of determinants of and access to care

The next session followed a similar format in that Mr. Jim Rosen, author of the Position Paper, presented its main conclusions and findings regarding adolescent access to pregnancy care. He posed the questions of whether adolescents are disadvantaged in their access to and use of pregnancy care and if the determinants of access affect adolescents differentially compared with older women. In terms of the scope of services, the discussion was guided by the essential package of pregnancy care, based on WHO Recommended Interventions for Improving Maternal and Newborn Health. The presentation discussed the use of antenatal care, the use of skilled delivery, and newborn vaccination rates. Both demand and supply side determinants were closely examined (See Appendix I: Slides– Determinants of and Access to Pregnancy Care by Jim Rosen).

Following the overview presentation, Dr Adepeju Olukoya of GWH provided discussant remarks. She pointed out the importance of differentiating between utilization, access to care, and control of resources. Some adolescents have access, but do not use the services because of perceived salience of their conditions and symptoms, quality of the service, attitude of health workers, etc. Concerning access to, and control over resources, these are related to structural determinants of health and gender equality issues. Even though these are not direct clinical care issues, they affect who actually benefits from available clinical services.

Furthermore, the paper notes that 4 out of 16 examined studies show some difference in access to care for adolescents; Also some of the countries cited (e.g. Bangladesh, India & Indonesia have lower rates of skilled attendance at birth. Some of these countries (three of those four studies) and all of the countries mentioned above are among those with the highest maternal mortality rates. The paper needs to make these connections to fully reflect the reality of adolescent pregnancy care. Many adolescents may have access to care, but do not use it because of quality of care issues such as not being treated well, or they lack resources, or for other reasons that need closer examination. The paper also needs to touch upon the area of adolescents who do not use health care services optimally, as there could be significant room for effective interventions there. The paper also needs to say more about abortion and post-abortion care, the use of contraceptives, and the role of adolescent fathers in accessing care. It would also be helpful to integrate the work of the Commission in Social Determinants of Health into the existing framework of determinants used in the paper. She also suggested and it was agreed that if possible, it would be useful for the paper to prioritize key determinants of accessing health care for pregnant adolescents. Indirect evidence and insight could also be gained from looking at access to other services by adolescents, for example, access and use of anti-retro viral drugs. It could also be helpful to categorise countries in order to classify the care required e.g. for countries that have adequate health care systems, low maternal mortality, but high adolescent pregnancy rates (e.g. US, UK), the care package must include X, Y and Z; in countries with limited health care and high maternal mortality rates, as well as high adolescent pregnancy rates (e.g. Nigeria), the care package must include X, Y and Z, and so on. The paper should also acknowledge from the outset that in many countries there is poor utilization of maternal health services overall, that is, for both adolescents and adults. Following discussant remarks, a brief plenary discussion ensued before participants worked in their small discussion groups.

From here, participants assembled into smaller working groups to discuss specific questions related to determinants of and access to care by pregnant adolescents (see Appendix D for question matrices used in the group work). Participants generally agreed with the mixed answer to the question the Position Paper poses regarding whether adolescents are relatively disadvantaged with regard to use of the essential package of pregnancy care. The Paper notes, for example, that almost all small-scale studies find substantially worse use of antenatal care for pregnant adolescents. Information from national surveys, however, shows that adolescents fare worse compared to older women in some countries but better in others. Participants urged greater nuance in differentiating between access and use of services. They further recognized some of the limitations of the available studies, including the relatively few studies that control for confounding influences on utilization, the problem of using indicators of care that capture what it means for a pregnant woman to use the care “adequately,”

and the paucity of studies on many of the important aspects of adolescent pregnancy care, including on breastfeeding, abortion and post-abortion care, aspects of post-partum care, and the involvement of fathers.

The Position Paper presented a framework for the determinants of access to care that included both demand and supply elements, and attempted to answer whether these determinants affect adolescents differentially compared with older women. In their small group discussions, participants again noted the deficiencies in the underlying evidence and called for a more systematic review of the factors. Participants also questioned the framework used to delineate the determinants, suggesting that it may be more appropriate to draw upon the framework developed by the Commission on the Social Determinants of Health. Participants also suggested tapping into the broader literature on social determinants, including on those cultural and traditional norms that determine the gender roles and power relations.

5.5 Position paper review of adolescent-specific interventions for pregnancy care

The last part of the Position Paper to be reviewed concerned the data and literature on adolescent-specific interventions. The overview presentation by author Jim Rosen examined the consensus on what might be different for adolescents in terms of interventions at the individual, family, community level, as well as within health services and health systems. The presentation touched on pregnancy prevention, as well as adolescent-specific content and organization of pregnancy care. It was noted that we know very little about the impact of interventions in the legal, policy, and regulatory environment. We also know virtually nothing about cost-effectiveness, or cost-benefit of adolescent pregnancy care programs. (See Appendix J: Slides– Adolescent-specific Interventions for Pregnancy Care by Jim Rosen).

Following the overview presentation, Jelka Zupan of MPS provided an extensive overview of the existing WHO guidelines on interventions as set out in the Integrated Management of Pregnancy and Childbirth (IMPAC). She also drew upon the WHO Recommended Interventions for Improving Maternal and Newborn Health and touched upon a range of considerations for interventions. She noted the importance of appropriate terminology because it shapes the way we provide care and package services. For example, she prefers the term “pregnant adolescents,” which makes it clear that people – mothers and children – are at the centre of these interventions, rather than the term “adolescent pregnancy,” which denotes more of a condition. Her presentation centred on using data to design programming, working with health workers and young mothers, factoring in differences between urban and rural settings, using policies, laws and regulations, integrating quality of service delivery, and the specifics of health promotion at the community, family and individual levels. Overall, she stressed effective case management to properly equip adolescents with all the services and information they need to have a safe and successful pregnancy. There also needs to be coordination and clear understanding within WHO on the terminology and best standards for interventions. (See Appendix K: Slides– Discussant Remarks on Adolescent-specific Interventions -Jelka Zupan).

Following discussant remarks, a brief plenary discussion ensued before participants worked in their small discussion groups (see Appendix D for question matrices used in the group work). One participant stressed the need for programme responses to be multifaceted. Several participants also underscored the need to work beyond the health sector and to strengthen interventions related to education and employment. It is critical to consider what happens outside the health centres, as non-health actors are key to forming the overall maternal newborn health care programmes. For example, in conducting maternal death reviews, how do we ensure that the information filters back to communities so that they can be supported in developing responses.

From here, participants assembled into smaller working groups to discuss specific questions related to interventions for pregnant adolescents. Participants generally agreed with the need for adolescent-

specific interventions for pregnancy care, but also recognized the limitations of the existing literature on intervention effectiveness literature as a guide to help countries choose appropriate organization and content of services. As with the evidence on health impacts and use of services, participants recommended carrying out a systematic review of the intervention effectiveness data. They also suggested drawing on a wider range of intervention research, recognizing that while relatively few studies have examined adolescent pregnancy care per se, many others have looked at other aspects of adolescent health, and their findings may have relevance to the design of appropriate pregnancy care. With regard to individual, family, and community interventions, participants suggested greater attention to male involvement, violence in pregnancy, and distinguishing between married and unmarried adolescent needs. With regard to clinical and outreach interventions, participants agreed with the need to build health worker capacity to address the specific needs of adolescents, and putting special emphasis on post-partum care. Participants discussing health systems noted that lack of strong evidence does not mean that changes in health systems have had no impact on adolescents' use of pregnancy care and pregnancy outcomes. Participants suggested further research into the impact of legal and regulatory changes in particular, including on issues such as keeping pregnant girls in school, legalization of pregnancy termination, and providing free care for adolescents.

5.6 Mid-point synthesis

Midway into the meeting, Dr. Dina Khan, author of the previous 2003 in-depth review on adolescent pregnancy, prepared a synthesis presentation (See Appendix L: Slides– Mid-Point Synthesis by Dr. Dina Khan). This marked a shift in the meeting's focus, from one that centred on reviewing evidence and information, to one that would now concentrate on reviewing existing work and delineating key actions to advance WHO work on adolescent pregnancy.

In her comments, Dr. Khan focussed on what has evolved over the last five years and summarized what has been learned from the updated review. She noted that the evidence around the many aspects of adolescent pregnancy is not perfect and important questions remain. Nevertheless, she suggested that it is time to move into action based on what we do know, while we continue to gather much needed evidence in parallel processes. One example of moving forward would be to integrate some of the elements of the basic package in the existing MCH/Safe Motherhood Programmes.

Dr. Shyam Thapa, WHO RHR Department, added to these remarks by noting the importance of integrating the findings we have into existing tools and guidelines for maternal care. He noted that the importance of coordination and cooperation within WHO cannot be overstated. He said that in reviewing the evidence for purposes of identifying certain position, the main question that needs to be asked is: what level of evidence is required to answer a specific policy or programmatic question? In this context, he suggested that it would be helpful to categorize available evidence in terms of a "gold, silver, and bronze" standard, which corresponds to "probability, plausibility, and adequacy" levels of evidence. Much of the information reviewed in the Background report may fall into the later two standards, which may be adequate for many policy and programmatic questions. We have evidence, but it may be weak. We need to categorize the strength of the evidence and match this to the level required to answer specific policy and programme questions. He also suggested that it would be useful to classify the studies in terms of low-to-high income countries, which is one way of providing the "context" to the results. On the rigour of research methodologies, he cautioned that one must be careful not to compare results that obtained using very different methodologies.

On the rigour of research methodologies, we must be careful not to compare results that obtained using very different methodologies. We need to have several multi-country studies that are comparable, which is expensive to do, but very valuable. As a community, we need to agree on methods and work to establish a community of practice of researchers in the field of adolescent pregnancy that allows us to move to the gold standard on research and evidence. This can include a range of approaches, from large randomized trials to evaluations of small-scale project-based results.

5.7 Panel Discussion – perspectives and responses of international agencies



As a part of the meeting's shift in focus to action-oriented planning, a lunchtime panel on the second day explored the perspectives and responses to adolescent pregnancy from partner agencies.

Dr Vincent Fauveau, Senior Maternal Health Advisor with United Nations Population Fund (UNFPA) in Geneva, gave an overview presentation of UNFPA's work in the area of addressing adolescent sexual and reproductive health (ASRH) (See Appendix M: Slides– Partners Panel – Presentation by UNFPA). He touched briefly on global and regional trends, the health challenges posed by adolescent pregnancy, and the risks associated with child marriages. He stressed that UNFPA is working to mainstream adolescent concerns into all country

programmes. This includes two key areas of ASRH work: 1) Facilitating gender-sensitive, life skills-based, SRH education; and 2) Promoting a core package of health and SRH services as part of a multi-sectoral development strategy for young people.

Ms Jenny Truong, Reproductive Health Technical Advisor with the United States Agency for International Development (USAID), presented the agency's efforts and support in addressing adolescent pregnancy (See Appendix N: Slides– Partners Panel – Presentation by USAID). One of the agency's areas of global leadership is in youth reproductive and sexual health. In the 1990s, the Office of Population and Reproductive health supported a 10-year program that focused on reproductive health and HIV prevention among young people: the first was called FOCUS on Young Adults and the second called YouthNet. USAID continues to share lessons learned from these initiatives, but also works to ensure that a youth lens is applied to the agency's research, policy and advocacy, service delivery, and monitoring and evaluation. Ms. Truong outlined six main areas in which the Agency works to prevent unintended pregnancy and to ensure a successful transition to adulthood. This includes working to: 1) Provide information about SRH; 2) Expand access to contraceptive options; 3) Reach post-partum adolescent with messages about family planning; 4) Promote healthy timing of the first birth and marriage; 5) Generate data and disseminate best practices (this includes work on DHS data and an inter-agency youth working group); and 6) Adapt high-impact maternal mortality interventions to adolescents.

Ms. Kimberly Gamble-Payne, a Senior Adviser for Human Rights and Gender in Division of Policy and Practice at United Nations Children's Fund (UNICEF), presented an overview of the work of the Adolescent Development and Participation Group. Although UNICEF is generally associated with working with children under five years old, a demographic imperative obliges a response to the needs of all children 18 years of age and under. Ms. Gamble-Payne stressed this moment of opportunity, as there seems to be a convergence of interests and multidimensional momentum around the needs of adolescent girls. She mentioned that UNICEF is increasing the number of adolescent development officers in country offices and integrating adolescent's issues in the five main areas outlined within UNICEF's Medium-Term Strategic Plan. These include: Basic education and gender equality, 2) Health 3) HIV/AIDS 4) Protection from exploitation, violence and abuse, and 5) Policy, advocacy and partnerships.

Ms Elizabeth Lule, Manager, ActAfrica at the World Bank, gave a broad overview of the Bank's structure and current directions. This includes areas such as social protection, infrastructure, energy, and rural electrification, the human resource side of the health sector, as well as health insurance. Each of these areas can have positive spill over effects on adolescent development. Ms. Lule also touched on several important lessons learned from past efforts to promote adolescent development. These include: adopting a system-wide and cross-sector approach, as aspects of adolescent development cut across many areas;

the need to balance the supply and demand side of interventions; the need to improve quality of services, as well as access/ quality; the need to enhance capacity and to foster community linkages that support behavioural change; and finally, we are coming up short on scaling-up evidence-based interventions, which requires a good results framework.

Dr Chandra-Mouli, of WHO's Child and Adolescent Health Department, added to the panel's remarks by noting that as UN agencies and partners, we work around a shared vision. This stems from the clear direction provided by the MDGs, as well as the CRC and the Convention on the Elimination of all Forms of Discrimination against Women (CEDAW) perspective, in terms of looking at adolescent needs, as well as rights. The niche areas that WHO can bring to the table are 1) To advocate to a multi-sectoral approach to adolescent health based on sound evidence and strong normative data (e.g. the technical report on HIV/ AIDS is a concrete example of this, as it delineates the role of various sectors); and 2) To clearly delineate the role of the health sector, within this multisectoral approach, and with an emphasis on the stewardship role of ministries.

Dr. Viviana Mangiaterra, of WHO's Making Pregnancy Safer Department, added that from the perspective of the maternal health component, there is a need to step in and ensure that adolescents are not adding to the heavy burden of maternal mortality. Attention is growing towards achieving MDG 5 on maternal health, which is currently not on track in many regions and countries. There are also recent WHO resolutions on gender, maternal health and other areas calling for action in countries and requiring a strong and collaborative response. The data is quite compelling to step up the work and make it more visible and effective. We can use adolescent pregnancy as a model for organization and cooperation across departments and organizations.

Comments following the panel's presentation included noting that new actors are taking up adolescent development. For example, a group of partners that include the private sector (e.g. Nike) have recently launched the "Girl Effect" initiative. The corporate sector and social entrepreneurs are becoming increasingly involved in gender and youth development. Agencies and partners must realize they have a new audience that also requires evidence and clear bottom-lines. It was also noted that agencies such as UNFPA and UNICEF are decentralized and it depends on the country teams and their priorities and access to support in terms of being able to adequately address adolescent needs. Finally, it was recognized that as guidelines and tools are developed to address adolescent development needs, it would also require capacity-building efforts at the regional and country levels. This task should not be underestimated.

5.8 How WHO Regional Offices are addressing adolescent pregnancy

Following the lunchtime panel, the meeting resumed with a series of presentations from each of the WHO regional offices in attendance, prepared jointly by the Regional Advisors for CAH and MPS. The presentations focused on what WHO is currently doing to address adolescent pregnancy in the various regions and countries, in order to support the review and prioritization of forward-looking actions in the remaining small working group sessions.

The **Regional Office for Africa** noted that while few specific interventions target adolescent pregnancy, they have produced advocacy and guidance materials on maternal health. This includes initiatives such as the African Road Map for Maternal and Child Mortality reduction, an advocacy tool for repositioning family planning, and support to an African Regional Strategy for Adolescent Health. Some of the priority needs include strengthening the health sector to better respond to the specific health needs of adolescent through implementing adolescent-friendly health services (AFHS), as well as strengthening partnerships in supporting countries in the implementation of the road map and AFHS standards. (See Appendix O: Slides– Regional Presentations – Regional Office for Africa).

The **Regional Office for Europe** presented data and findings on overall regional trends. The presentation outlined what the regional office is currently doing in terms of 1) Interventions to strengthen safe motherhood irrespective of age; 2) Interventions to strengthen adolescent health care irrespective

of the issue and then in an area of overlap, 3) Interventions to address adolescent pregnancy. In the area of obtaining strategic information, for example, this includes ensuring indicators on adolescent pregnancy in the health database, looking at issues around adolescent access to safe abortion services, and undertaking confidential enquiries into maternal deaths. The region is also undertaking work in service delivery and supporting policy development. Additionally, the office is looking at mainstreaming adolescents in ongoing work, such as an assessment tool for the quality of hospital care for mothers and newborn babies, effective perinatal care training (training package of the WHO EURO) and updating country profiles. The presentation concluded with a real life story of a 16 year-old woman whose death could have been prevented through better access to maternal care. (See Appendix P: Slides– Regional Presentations – Regional Office for Europe).

The **Regional Office for the Eastern Mediterranean** presented an overview of the magnitude of adolescent pregnancy in the EM region, national measures addressing the problem, WHO/EMRO activities addressing the problem, as well as some of the challenges and opportunities to address the problem from a WHO perspective. For example, one of the activities to address the issue is a new reproductive health program monitoring & evaluation framework that, among other core RH indicators allows monitoring: a) adolescent birth rate, b) percentage of providers trained in youth-friendly reproductive health services provision; and c) percentage of reproductive health service delivery points providing youth-friendly services. In terms of going forward, it was noted that WRH and CAH have a unique opportunity not only for promoting the health of mothers, newborns, children and adolescents, but also to work together to prevent teenage pregnancy. In addition to collaborate with outside donors and organizations, who are concerned and advocate for adolescent reproductive health. (See Appendix Q: Slides– Regional Presentation – Regional Office for the Eastern Mediterranean).

The **Regional Office for South-East Asia** provided an overview of available data and regional trends in areas such as percentage of births that are unwanted in adolescents versus older women or the unmet need for contraceptives. They noted progress so far, which included initiatives such as national strategies on ASRH with a focus on adolescent pregnancy, national standards developed in 4 countries, and adolescent health training packages that address pregnancy prevention and care. In terms of challenges, these include a lack of disaggregated data on adolescent pregnancy, outcome and care, which hinders advocacy; a dichotomy in 'entry point' at the Ministry of Health level – Maternal health or Adolescent sexual and reproductive health?; lack of evidence on program interventions in developing countries; unfavourable laws and policies (contraception, abortion); limited advocacy within WHO on MDG 4 and 5; and funding. (See Appendix R: Slides– Regional Presentation – Regional Office for Southeast Asia).

The **Regional Office for the Western Pacific** provided an overview of available data that included, for example, age-specific fertility rates (15-19 years) and proportion of the population aged 10-24 years in selected countries. Presenters noted that the current level of adolescent childbearing correlates with early age at marriage and that a strategic assessment by UNFPA found that adolescents, even those living relatively close to health facilities, were not likely to attend prenatal care services. This is mostly due to lack of awareness about its importance, as well as being shy and intimidated. The presentation concluded with a succinct chart that outlined responses to address the reproductive rights and needs of adolescents in the region. This included: laws and legislation, programmes and strategies, advocacy campaigns, the establishment of youth-friendly services/school based clinics, training of health care providers/clinic staff, and adolescent development and health being included into medical/nursing training curriculum. (See Appendix S: Slides– Regional Presentation – Regional Office for the Western Pacific).

6. Refining WHO actions

6.1 Review of current WHO actions

During the last session on the second day, workshop participants worked in their regional groups to take stock of current WHO actions at the regional and country level and to brainstorm on major outstanding issues or challenges in addressing adolescent pregnancy. The overview chart below summarizes results of their discussions.

Overview of actions being undertaken to address adolescent pregnancy in regions and countries

Actions currently undertaken by WHO in countries	Strengths	Weaknesses
Regional Office for Africa		
(Advocacy) WHO supporting MOH in Advocacy for partnership, in adolescent health and development (ADH) and Maternal Mortality reduction	Credibility for advocacy Availability of advocacy material to be used at country level	Tools not well disseminated Tools not timely developed and disseminated
(Technical Support) Assist country to develop national planning documents (ADH strategy, Road Map, AFHS Standards, implementation and monitoring tools).	Credibility in technical support	Lack of regional and national evidences Lack of accurate data on ADH Limited capacity of Ministry of Health to scale-up intervention at district level
(Technical Support) Assist country in capacity building on research in RH and program management		
(Monitoring Progress) Assist country to select appropriate indicators from generic list		
(Monitoring Progress) Assist country to develop monitoring tools	In put in measuring quality	Limitation in capacity at country level in monitoring/ documentation/sharing result.
(Supporting Research) WHO is working with collaborative centres on research on sexual and reproductive health	Existence of local capacity to generate evidence	Centres are not sufficiently used Result not well disseminated and used
(Supporting Research) Supporting countries to conduct operational research	As above	As above
(Fostering partnerships) Promote partnership at country level	Recognition of the role and added value of each partner	Conflicting messages from different departments of WHO on adolescent health
(Fostering partnerships) WHO mobilizes country resources from donors (e.g. EU funds) and supports countries to mobilize additional resources	Credibility and good connection with donors	Delay in funds disbursement Limited capacity in funds absorption (countries)

Actions currently undertaken by WHO in countries	Strengths	Weaknesses
Regional Office for Europe		
(<i>Supporting Research</i>) Health database – 2 indicators on adolescents, working on issues around adolescent access to safe abortion services, undertaking confidential enquiries into maternal deaths	Good interventions in place to strengthen safe motherhood irrespective of age	Region is diverse in economic development, cultural background, attitudes toward SRH issues, especially in adolescents, and in its availability, accessibility and quality of care.
(<i>Technical Support</i>) MPS/European strategic approach to improve maternal and perinatal health: specifically addresses adolescents and safe motherhood.		Decreasing human and financial resources available at regional and country level to implement interventions for making pregnancy safer and adolescent health based on needs and agreed workplans
(<i>Monitoring Progress</i>) European CAH Strategy: Action tool is being reviewed to integrate new evidences on effective interventions at different level for making adolescent pregnancy safer.		
(<i>Advocacy</i>) Application to human rights approach to review laws and regulations that impact on adolescents access to SRH services		
Support countries in review abortion related regulations		
Contraceptives availability (especially in relation to Family Medicine reform)		
(<i>Technical Support</i>) WHO RHR clinical guidelines on contraception		
Effective perinatal care training (training package)		
Near miss case review, abortion part of NM definitions		
Strengthening school health services for better adolescent health and development outcomes		
Broadening options for pregnancy terminations		
Regional Office for the Americas (done by colleagues familiar with region, only an approximation)		
(<i>Advocacy</i>) Prevention of adolescent pregnancy and care/ management of pregnancy:	High political support on issue of adolescent pregnancy and sexual and reproductive health in selected countries e.g. Colombia, Brazil, Chile, Peru, Ecuador, Bolivia, Venezuela, Cuba, El Salvador, Argentina, Barbados, Uruguay, Panama, Jamaica, Guyana, Mexico	Not all countries are getting support
Updated regional policies		
Promotion of youth-friendly services		
First Ladies initiative on prevention of adolescent pregnancy (Dominican Republic, Colombia and others)		
Convenio Hipolito Unanue—Andean Countries Initiative on Adolescent Pregnancy Prevention	Sub regional policies	

Actions currently undertaken by WHO in countries	Strengths	Weaknesses
(Advocacy) Prevention - Promotion of youth-friendly services with a focus on adolescent sexual and reproductive health (Colombia, Brazil, Chile, Ecuador, Bolivia, El Salvador, Argentina, Guyana).	<p>Some supportive legal frameworks (e.g. State of Sao Paulo) to support integrated adolescent health care and services</p> <p>Human rights approach a powerful entry point to address sexual and reproductive health/adolescent pregnancy.</p> <p>ICPD and Beijing plan of actions are also platforms for advocacy and policy development.</p>	
<p>(Technical support) adolescent sexual and reproductive health /adolescent pregnancy prevention and care in Guyana, Brazil, Central America, and Chile, Colombia, Argentina among others.</p> <p>Andean countries have a subregional plan to address adolescent pregnancy with emphasis on prevention</p>	Knowledge bank	Limited evaluation on YFS, (prevention and care)
<p>(Technical support) Development of the Centro Latinoamericano de la lengua portuguesa/ espanol for Health Care Providers in Adolescent Health</p> <p>Evaluation and development of guidelines for youth-friendly services</p>		
<p>(Developing guidelines & tools)</p> <p>Specific guidelines in adolescent sexual and reproductive health was developed and disseminated, Review of the evidence on adolescent pregnancy prevention and care</p>		
<p>(Supporting Research) Global review of causes of maternal mortality among adolescents (ongoing)</p> <p>Maternal and perinatal morbidity and mortality associated to adolescent pregnancy based on SIP data.</p> <p>Specific assessment tool for adolescents- CLAP has a comprehensive adolescent health record that needs to be updated based on latest evidence and country experiences</p>	<p>MDGs an entry point of maternal mortality reduction is very powerful to position prevention and care of adolescent pregnancy.</p>	
(Fostering partnerships) Interagency group on maternal mortality and on adolescent health		

Actions currently undertaken by WHO in countries	Strengths	Weaknesses
Regional Office for the Americas (done by colleagues familiar with regions, only approximately)		
(Advocacy) Three manuals on adolescent health education, that covers ARH are regionally developed (separate for boys; girls; parents and teachers and media);	<i>Availability of culturally sensitive information and content.</i>	1) Lack of comprehensive and systematic advocacy package specific to adolescent pregnancy. 2) Lack of evaluation of existing interventions; 3) Education materials do not reach its audience; 4) Lack of programming approach to ADH
(Interventions) 1) Different types of youth-friendly services piloted in Egypt and Tunisia; 2) With technical support from WHO/EMRO adolescent health strategies are developed in Iran, Syria, UAE and Oman	Different types of interventions to be evaluated before scaling up and/or be proposed for intercountry exchange of experience. Conducted Regional Adolescent Health situation analysis may: Guide development of EMRO adolescent pregnancy prevention and care package Provide baseline information and contribute to HQ/ADH global EMRO systematic review	Lack of age disaggregated data; Lack of Region specific information on socio-cultural and economic determinants of adolescent pregnancy; Lack of adolescent pregnancy prevention and care tools package
(Monitoring Progress and Evaluation) New reproductive health program monitoring and evaluation framework with three adolescent reproductive health indicators	Have indicators to monitor: 1. Adolescent birth rate; 2. % providers trained in youth-friendly reproductive health service provision; 3. % Reproductive health service delivery points providing youth-friendly services.	1) Lack of systematic monitoring and evaluation of adolescent sexual and reproductive health programs; Lack of consistency in definitions of adolescent age groups among organizations; 2) Lack of age disaggregated data; 3) Weak human and structural capacities focused on monitoring and evaluation of adolescents' reproductive health.
(Supporting Research) Desk review performed on socio-cultural determinants of adolescent health	Research on adolescent sexual and reproductive health promoted;	Lack of quality research and information on protective and risk behaviour; Lack of translating available research evidence into effective interventions and programs;
(Fostering partnerships) Joint RD planning (WHO/UNICEF/UNFPA/WFP)	Lack of regional information sharing and coordinated actions among organizations on adolescent pregnancy	EMRO is competing with other regional priorities; EMRO is an underfunded area of work in WHO.

Actions currently undertaken by WHO in countries	Strengths	Weaknesses
Regional Office for the Eastern Mediterranean		
<p>(Advocacy)</p> <p>Three manuals on adolescent health education that covers ARH (for boys, girls, parents and teachers);</p> <p>Pilot youth-friendly services (e.g. Egypt and Tunisia);</p> <p>Adolescent health strategies in some countries</p>	<p>Advocacy on ARH conducted in the past;</p>	<p>Lack of strong and systematic advocacy specific to adolescent pregnancy.</p> <p>Lack of evaluation of existing interventions;</p> <p>Education materials do not reach its audience;</p> <p>Lack of programming approach to ADH</p>
<p>(Monitoring Progress) Monitoring and evaluation framework with adolescent indicators:</p>	<p>Have indicators on:</p> <ol style="list-style-type: none"> 1. Adolescent birth rate; 2. % providers trained in youth-friendly reproductive health service provision; 3. % Reproductive health service delivery points providing youth-friendly services. 	<p>Lack of systematic monitoring and evaluation of adolescent sexual and reproductive health programs;</p> <p>Lack of consistency in definitions of age groups among organizations;</p>
<p>(Supporting Research) Desk review perform on socio-cultural determinants of adolescent health</p>	<p>Research on adolescent sexual and reproductive health promoted;</p>	<p>Lack of quality research on protective and risk behaviour;</p> <p>Lack of translating available research evidence into effective programs;</p>
<p>(Fostering partnerships) Joint RD planning (WHO/UNICEF/UNFPA/WFP)</p>		<p>ADH not a single priority on the agenda?</p>
Regional Office for South-East Asia		
<p>(Advocacy) Fact sheets on adolescent pregnancy - National and sub national data on prevention and care</p>	<p>Country specific data and information</p>	<p>Does not cover evidence for interventions</p>
<p>(Advocacy) Regional and national strategy on RH and ASRH - both address pregnancy care and prevention</p>	<p>Includes adolescent pregnancy</p>	<p>Strategy not translated into action in all countries</p>
<p>(Technical Support) National standards on AFHS</p> <p>Service package includes adolescent pregnancy</p>	<p>Focus on quality of health services</p>	<p>None</p>
<p>(Technical Support) Updating RH strategy in countries and supporting ASRH strategy development</p>	<p>Opportunity to strengthen adolescent pregnancy</p>	<p>Need to converge adolescent pregnancy at country level</p>
<p>(Monitoring Progress) Quality and coverage assessment of AFHS</p>	<p>Adolescent pregnancy care and prevention addressed</p>	<p>Overall RH services not included</p>
<p>(Monitoring Progress) MDG 4,5 including 5b on percent of births under 20, collecting national data</p>		<p>Not included in HMIS</p>

Actions currently undertaken by WHO in countries	Strengths	Weaknesses
(Developing guidelines & tools) Adaptation of IMPAC and OP package on AFHS	Focus on care provision and prevention	Orientation of HW on adolescent special needs not well addressed by IMPAC
(Fostering partnerships) Regional Countdown on MDG 4 and 5	High level advocacy	Adolescent pregnancy not adequately addressed
(Fostering partnerships) AFHS implementation	UNFPA and INGOs on board at regional and country level	UNICEF World Bank and USAID to be brought on board
Regional Office for Western Pacific		
(Advocacy) Multiagency 7 country meeting on ADH held 12/2008 Manila, Sharing information, disseminating 4 S strategy, framework, inputs for regional strategic directions	All focal points from focus countries and select country offices were present, WHO, UNFPA, UNICEF, orientation for participants on ADH/ARSH conducted	Not all WHO country staff were present.
(Advocacy) Intradepartmental collaboration on RH, MPS, ADH to improve internal advocacy	3 units: MPS, RHR, CAH were working together Working closely with Division Health Systems Development Strong support from strong management	Lack of formal linkages;
(Advocacy) Adolescent Framework: policy brief for advocacy		
(Advocacy) Regional orientation - Program managers in countries, e.g. Philippines, China, Cambodia	Advocacy tools are available Sufficient interest in ADH	Multiple activities required to build Needs ongoing, sustained work
(Advocacy) Bi-regional orientation of program managers/country focal points of select countries on lessons learnt from AFHS implementation		
(Technical Support) Development of regional strategic direction; MPS, RH, Regional strategy	Getting all stakeholders together on ARSH	
(Technical Support) Finalize policy, strategic framework in ADH in the Philippines, Cambodia, China, Viet Nam, Lao	Supported MOH, brings prominence to issue of adolescent pregnancy	Challenge: harmonize all the various priorities and frameworks of WHO, UNFPA, UNICEF
(Technical Support) Inter country building capacity for implementation - AFHS (OP, Job Aid, Standards and Guidelines)	Brings prominence to issue of adolescent pregnancy; integration of nursing and midwifery curricula on Adolescent Health (in Mongolia, Philippines TBD)	Limited number of countries; costly, high degree of staff turnover
(Technical Support) Strengthening and utilizing of information for Planning, Implementation at scale and monitoring - Cambodia, China, Lao, PNG, Fiji, Korea	Rationalizing health care delivery system	Many gaps in data, program, few are being filled; appropriate indicators do not exist.

Actions currently undertaken by WHO in countries	Strengths	Weaknesses
(Technical Support) COMBI (communication for behaviour change impact) on adolescent pregnancy Philippines, China (breastfeeding)	High priority for MOH	This is a current gap for Philippines.
(Monitoring Progress) Inter-country cost assessment of AFHS - Mongolia, Viet Nam, Philippines		
(Monitoring Progress) Country workshops China, Viet Nam		
(Monitoring Progress) Short program review of ADH, including AFHS in Mongolia		Tools not available
13. Currently developing regional framework for accelerating progress towards achieving MDGs 4 & 5 - To serve as a guideline for certain countries, responds to needs expressed by member states	Builds on existing strategy documents; access to technical expertise, access to historical evidence and effective examples (best practices, e.g. Malaysia, Viet Nam)	
(Developing guidelines & tools) Framework for ASRH - 3 main pillars for countries to work on: life skills, service delivery and supportive environment	Multi-agency cooperation, accepted by countries	Countries still lack resources for implementation, particularly for life skills education

6.2 Proposing and prioritizing key actions in regions and countries

The third day of the meeting resumed with participants taking up discussions in their regional working groups. Each group received hard copies of their notes on the major issues in their regions and countries (typed up and categorized from the discussions yesterday) and a copy of their completed chart on current activities. They reviewed these materials and used them as a starting point to identify what new or reinforced actions they should consider to better assist countries in working with adolescent pregnancy. These actions were then prioritized and further delineated in relation to links to current WHO work, opportunities (e.g. partners, other existing initiatives, donor support) and threats (e.g. obstacles to overcome). Groups also noted any areas where they felt the regions required specific support from WHO Headquarters.

The inputs from the six regions are summarized below:

Regional Office for Africa

Priority1: Assist countries to incorporate adolescent pregnancy in the road maps addressing health challenges to ensure that adolescent pregnancy issues are reflected in the action plans of countries.

Opportunities: Almost all countries have a national road map that is accepted and well supported by key stakeholders; existing training materials on ADH for adaptation.

Threats: Insufficient expertise at regional and country level, particularly among health providers.

Support required from HQ (if any): Assist to develop expertise

Priority 2: Assist countries to develop /adapt monitoring and evaluation tools and guidelines in order to improve the quality of health services.

Opportunities: Generic and some country tools and guidelines currently exist, as a starting point.

Threats: Difficulty to reach consensus within partners

Priority 3: Identify/review/adapt/disseminate advocacy tools focused on adolescent pregnancy in order to increase political commitment at regional and country level.

Opportunities: Regional meetings (AU) and country meetings; Availability of data to use for advocacy; Existence of the road maps and "deliver now" campaigns.

Threats: Insufficient utilization of available advocacy material at regional and country level; Socio-cultural barriers to adolescent sexuality issue, and political instability.

Support required from HQ (if any): Assistance in developing the tools and collecting relevant data.

Priority 4: Strengthen partnerships on adolescent health in order to avoid duplication and competition.

Opportunities: There are UN interagency meetings and occasional consultations at regional level, as well as joint UN meetings at country level

Threats: Fragmented planning meetings.

Support required from HQ (if any): Encourage UN interagency meetings

Regional Office for Europe

In light of the regional office resource constraints to implement interventions for adolescent health and making pregnancy safer, this working group offered a slightly different approach. They prepared priority actions based on two scenarios. Plan A lists priority actions assuming a continued reduction in human and financial resources, whereas Plan B outlines key actions should greater resources be available.

Plan A:

Priority 1: Update some of the existing Making Pregnancy Safer tools and approaches to include adolescent pregnancy issues and apply them in countries where funds are available. This includes a tool for the assessment of healthy system functions to improve maternal and perinatal health and a tool for assessing the quality of hospital care for mothers and newborn babies in making it sensitive to adolescent needs (WHO EURO).

Priority 2: Implement the RH and CAH and Gender (including male involvement) strategies in countries with more explicit focus on adolescent pregnancy whenever relevant.

Plan B: In addition to the work carried out under plan A, priority actions include:

Priority 3: To gather strategic information, expand the "health for all" database to include DHS-related indicators, collect confidential enquiries into maternal health and undertake strategic assessments in abortion care.

Priority 4: In the area of policy work, provide country support to incorporate a rights-based approach for policy review and apply MPS global and regional guidelines and related tools

Priority 5: In terms of services, provide effective perinatal care training package (WHO EURO) that are adolescent friendly, support countries to develop youth friendly health services, including quality of care standards, and strengthen school health services for better adolescent health and development outcomes. If possible, undertake near-miss case reviews, adapt WHO antenatal care package to regional needs, with special focus on the needs of adolescents, and support countries in integrating teenage pregnancy prevention and care in nursing training programmes.

Support required from HQ: Contribute to secure human resources and funds for implementation, provide technical support in selected areas, and assist in undertaking an integrated approach to services.

Regional Office for the Americas

* These are suggested priorities and related considerations noted by colleagues with experience in the region, presented in the absence of staff from the ROA.

Possible Priorities for Advocacy: Promote access to services for the most vulnerable adolescents, with specific emphasis on addressing financing and socio-cultural barriers (e.g. re-energize First Ladies initiative on adolescent pregnancy); Advocate for countries to use a core clinical adolescent history form; Create a regional interagency/interdisciplinary group on SRH of adolescents with a focus on adolescent pregnancy; and Promote medical, nursing schools to include a core curriculum covering the essential aspects of addressing adolescent pregnancy.

Possible Priorities for Technical Support: Provide clear standards and guidelines for adolescent pregnancy care; Strengthen the work of the Sao Paulo-based Centro Latinoamericano para habla portuguesa y espanol for training in adolescent health; Work to include a special adolescent pregnancy module within the WHO RH library (global); Review and update the current adolescent clinical history (SIA/CLAP CAH) as well as the IFC interventions including prevention and care for adolescents, and agree on key variables for monitoring; and Establish a core curriculum on pregnancy for students in all the disciplines involved with caring for adolescent (medical, nursing, psychologists, social work etc.).

Possible Priorities for monitoring progress: Assess the situation of adolescent pregnancy amongst the youngest (10-14), especially in excluded population and continue documentation of successful programs with special emphasis on identifying factors for success.

Possible Priorities for developing guidelines and supporting research: Review current WHO prenatal guidelines and update as appropriate to ensure adequate standards of care for adolescents; Ensure that the CAH-led systematic review of adolescent pregnancy interventions includes regional perspectives and captures the experience from LAC; Continue with CAH/RHR work on identifying age-specific causes of MM among adolescents worldwide and ensure it includes a LAC perspective.

Support required from HQ: CAH/MPS could assist by providing inputs and information on what is happening globally to inform the objectives and structure and activities of the regional interagency/interdisciplinary group on SRH of adolescents; Provide technical information and share experiences from other countries; Promote training for Spanish and Portuguese-speaking health workers from outside of the region; Promote the Sao Paulo-based Centre as a WHO collaborating partner; Provide inputs and guidance on the development of model evaluation protocols (CAH/MPS/RHR).

Regional Office for the Eastern Mediterranean

Priority 1: Enrich and Strengthen Strategic Information

- Use findings from the regional situation analysis of adolescent health that revealed that early pregnancy as one of the regional priority issues.

- Evaluate existing adolescent reproductive health pilot projects i.e. school-based health programs in Tunisia and project on youth-friendly services in Egypt.
- Contribute to the Adolescent reproductive health systematic review exercise conducted by ADH/HQ (EMRO)

Priority 2: Advocacy and Prevention Programme Interventions

- Based on EMRO situation analysis to develop a regional advocacy framework and package, which addresses both adolescent pregnancy prevention and care;
- Develop a regional premarital counselling guideline

Priority 3: Care Programme Interventions

- Development of ADH national strategies on adolescent pregnancy care and prevention;
- To develop/adapt adolescent pregnancy care guidelines and tools;

Priority 4: Monitoring & Evaluation

Hold an inter-country workshop on RH M&E;

Adapt core ADH indicators including early pregnancy;

- National human and structural capacity building on monitoring and evaluation of programme prevention and care of adolescent pregnancy;

Priority 5: To strengthen partnerships

Coordinate and collaborate with relevant units in WHO/EMRO and outside donors and organizations, which are concerned and advocate for Adolescent Reproductive Health (HQ/EMRO)

Support required from HQ:

- To provide guidelines and standards on: youth-friendly prevention and care services, core indicators on monitoring and evaluation;
- To advocate for using standardized definitions and collecting disaggregated data by age;
- To advocate and provide assistance for coordinated action among agencies globally and in the region.

Regional Office for Southeast Asia

High Priorities for advocacy: Advocate to countries on the problem of adolescent pregnancy and its contribution for reducing maternal mortality rates in the broader context of reproductive health; Facilitate the availability of data related to adolescent pregnancy, particularly to include the age of 10-14 and 15-19 years on different elements of reproductive health care.

High priorities for technical support: Develop/adapt and utilize the relevant guidelines and tools related to adolescent pregnancy; Strengthen monitoring system for policy and programmatic aspects of adolescent pregnancy; and hold multi-country meetings on adolescent pregnancy to support ongoing research activities and programme development.

High Priorities for fostering partnerships: Collaborate with UN agencies and other international NGOs and donors working in the areas of MNH/RH in addressing adolescent pregnancy and strengthen collaboration with government counterparts in addressing adolescent pregnancy. This is particularly in order to meet the commitment for achieving MDG 5 targets.

Support required from HQ: Funding, Technical assistance, Availability of the necessary guidelines/tools on adolescent pregnancy, Addressing MDG 5 targets in high-level meetings, Follow up of the Joint

Statement that leads to specific actions at RO and CO levels, Convening consultations, and Finalizing minimum list of indicators.

Regional Office for the Western Pacific

Priority 1: Develop a regional framework to accelerate progress towards achieving MDGs 4 & 5 and to serve as advocacy tool for member states, UN partners, & donor agencies.

Opportunities: The framework provides an opportunity to highlight issues related to adolescent pregnancy; Support from the top management.

Threats: Acceptance of sensitive issues e.g. abortion and sexual health among member states

Support required from HQ (if any): Technical advice and staff time

Priority 2: Review the existing position paper on advocacy for emergency contraception and safe abortion services to increase the impact of these interventions.

Opportunities: Convincing evidence from four countries - Mongolia, China, Vietnam and Cambodia.

Threats: These are two of the most difficult areas to promote and require strong advocacy based on evidence.

Support required from HQ (if any): Evidence on effectiveness and impact and on best approach for advocacy.

Priority 3: Develop standards and guidelines for provision of AFHS to provide more detailed and country specific strategies to follow up on existing framework.

Opportunities: Existing framework provides basis and broad parameters, UN partners were involved in the development and continue to involve in implementation.

Threats: May not have enough evidence on which approaches fit best for which country, require resources to develop and disseminate, costs are high

Support required from HQ (if any): HQ to provide generic standards and guidelines, which region will adapt, documentation of 'best practices' from other regions.

Priority 4: Collating, disaggregating, analyzing, and utilizing data on PAC, contraception, MMR, service utilization related to adolescent pregnancy to promote evidence-based decision making.

Opportunities: Provides an opportunity to produce evidence to inform policy and program for prevention and care of adolescent pregnancy.

Threats: The basic data itself may be absent, costs are high.

Support required from HQ (if any): Technical expertise and funds.

6.3 The roles of key stakeholders

The final round of small group working discussions took place in stakeholder groupings. Participants divided themselves in terms of four stakeholder interests: Academia-researchers-universities / Ministry of Health-Government-Service Provider / WHO Regional Offices and Headquarters / Agencies and Partners.

The session served as an opportunity to discuss, as a stakeholder group, some of the actions required to advance the prevention and care of adolescent pregnancy, particularly in terms of the priority actions raised in earlier sessions throughout the meeting.

Academics, Research Institutes and Universities

This group prepared a list of topics that require further study and action within their stakeholder group:

- Qualitative studies, e.g. verbal autopsies
- Closer examination of policy implementation and related impacts
- What makes adolescents different from other age groups
- How to get the young people to the clinic
- Barriers to access and utilization of health services
- Priority causes of maternal deaths
- Meta-analyses on adolescent pregnancies
- Community studies based on utilization
- Interventions research in developing countries
- Identify adverse outcome of adolescent pregnancies
- Mental illnesses in adolescent pregnancy
- Research for preventing adolescent pregnancies in Latin America
- Multi-site interventions for prevention of pregnancies
- Fistulas in adolescents
- Post-partum prevention of repeating pregnancies
- The magnitude of unsafe abortion and best options for post-abortion care
- Documentation and evaluation of intervention to prevent coercive sex that leads to unplanned pregnancies
- Information from developing countries on how many pregnancies result from non-consensual sex
- Why health risks are higher for adolescent mothers
- Short- and long-term consequences of the adolescence childbirth for the child

Ministry of Health, Governments, and Service Providers

This stakeholder group identified specific areas where they felt that they had the most ability to ensure progress. These areas included:

- 1) The prevention of early marriage - Government have a responsibility to:
 - Enact laws on age for marriage\ labour\sexual offences;
 - Sensitize communities; and
 - Promote universal education
- 2) Prevent adolescent sexual and reproductive health risk behaviours
 - Work with others to promote peer education, life skills, media information, school health promotion
- 3) Address the lack of Adolescent-Friendly SRH Services
 - Work with others to promote guidelines; training (pre/in service); infrastructure (different settings)
- 4) Work with others to address inadequate financial resources (build partnerships, advocacy, and shared responsibility)
- 5) Work with others to expand the limited evidence
- 6) Address the inadequate utilization of services (antenatal care, delivery, postpartum, including family planning)
 - Quality improvement, taking care of adolescent special needs (high risk groups), information, counselling
 - Parental/community/male partner sensitization/support

- 7) Provide access to safe abortions (limit unsafe abortions, improve post abortion care
 - Review laws/policies, build capacity for adolescent care (community, health facility), provide services, provide linkage to Adolescent sexual and reproductive health Services
- 8) Lack of standardized care package for pregnant adolescents (antenatal care, delivery, postpartum/postnatal care)
 - Work with others to review/adapt/develop tools, orientation/dissemination, document & share lessons learnt

WHO Regional Offices and HQ

This stakeholder group identified specific within specific areas for next steps. These areas included:

Coordination:

- Good coordination already exists across departments CAH/RHR/MPS on the regional level;
- There is a need for a common agenda for action for adolescent pregnancy in WHO HQ with clear delineation of responsibilities of contributing departments;
- To facilitate coordinating with partners, particularly on the country level it is important to communicate WHO niche which is to strengthen health sector response to adolescent pregnancy;

Research:

- In helping to fill research gaps identified in this meeting, WHO research agenda, especially HRP should involve the regional office as well as concerned HQ departments;
- The proposed systematic review should build on background paper for this meeting and should be done involving concerned departments in regional offices;

At the country level:

- Adolescent pregnancy could be the force renewing primary health care;
- We do not need parallel national programs for adolescent and adult women. We want one national programme, which addresses the special needs of adolescents through carefully tailored interventions;
- We need to work in a coordinated way to addressing adolescent pregnancy as a part of a broader approach to addressing reproductive health in selected countries.

Advocacy:

- There is a pressing need for the advocacy package containing advocacy tools and programmatic guidance as soon as possible;
- We need to strengthen the adolescent face of the Countdown.

Agencies and Partners

This group listed a number of priority actions. Those identified as high priority include:

- Harmonizing adolescent indicators, capturing, and usage in the district level; HMIS – stratifying according to age and quintiles, explicitly including adolescence issues. Incorporating more adolescent data and indicators into censuses, DHSs and MICSs;
- Concentrating on research to demonstrate what programs and interventions work; Generating and sharing knowledge;
- Improving collaborations and synergies, avoiding duplications, both in HQ level and in regional and country level;
- Ensuring that the adolescent-health people are part of the planning process and accelerating joint country support group for maternal and newborn health;
- Concentrating on institutional capacity building (regional and national; training, research) and on increasing the capacity of local research institutions;
- Stopping vertical programs and fragmentation;

- Working together to better define/redefine and restructure youth-friendly services, particularly in terms of cost effectiveness;
- Funding pilot programs that are specifically designed to address adolescent pregnancy;
- Concentrating on the most vulnerable groups;
- Concentrating on care to pregnant adolescents (access, equity, quality, coverage);
- Continuing with primary prevention/delaying early pregnancy/early marriage;
- Concentrating on interventions/programs that are outside of the official health system (education, social protection);
- Increasing advocacy targeting younger people in their language and their communications media;
- Continuing increasing inter-agency, inter-sector, and inter-ministerial partnerships;
- Introducing the specific needs of adolescents to pre-service training programs of maternal and newborn health human resources for health.
- Using the division of labour, strategic planning and management for results;
- Development partners should share and collaborate on their work plans to increase collaboration with bilateral donors and civil society organization

7. Moving forward: Summary remarks and key recommendations

By the closing session of the meeting, each group was in a position to present a synopsis of their small working group discussions and recorded inputs to Ms. Daisy Mafubelu, Assistant Director-General, Family and Community Health, the division of WHO which includes CAH, MPS, RHR, and GWH. This session, entitled Moving Forward, provided an opportunity to capture summary ideas and key recommendations to take forward following the meeting.

Ms. Razia Pendse of MPS presented a synopsis of the deliberations from the first day and half of the meeting that focussed on the review of the Position Paper (See Appendix T: Slides– Review and recommendations for the Position Paper – by Dr. Razia Pendse). Dr. Monir Islam of MPS confirmed the Department’s intention to review the inputs gathered from this meeting and to finalize and publish the Position Paper.

The key recommendations that emerged during this session or otherwise captured throughout the meeting include:

1) Finalize and circulate widely the Position Paper on Mainstreaming Adolescent Pregnancy in the WHO’s Making Pregnancy Safer Strategic Approach.

There were many suggestions over the course of the meeting on how to review, improve, and complete the Position Paper. Following this meeting, it is recommended that MPS take stock of the comments received as summarized in this report and work with Mr. Jim Rosen, the paper’s author, and other partners to integrate as many of the inputs as possible, within available time and resources. Some suggestions, such as the inclusion of a glossary or a section that further clarifies the limitations of the evidence, can be easily taken on board. Others, such as including a comprehensive evaluation of the strength of evidence and the application of quality filters, may require on-going, long-term work and continued cooperation across departments.

2) Use the Position Paper to create short, practical policy briefs that could provide guidance at both a programmatic and regional level.

It was acknowledged throughout the meeting that a challenge to advancing work on adolescent pregnancy is bringing the existing evidence into programmatic focus. There was general support for

using the Position Paper to make a series of shorter policy papers that could serve to practically orient the paper's findings into operative responses to specific aspects of adolescent pregnancy care. Some of these briefs could equally expand on the issues of the Position Paper from a regional perspective, based on areas that the Regional Offices identified as priority concerns by (taking into account, for example, Section 6.2 of this report, Proposing and Prioritizing Key Actions in Regions and Countries).

3) Strike a balance between advancing research on adolescent pregnancy, while moving ahead with an action-oriented agenda that responds to the needs of Member States. If possible, the WHO should determine a framework for gathering evidence on adolescent pregnancy prevention and care, linking interventions to intermediate outcomes, and eventually to long-term health impacts.

The participants at the meeting were resolute on the need to move the agenda forward on responding to the needs of adolescents in the absence of sufficient evidence. Recognising that governments are required to implement policies even in the absence of sufficient information, it was recommended that WHO pursue a parallel approach of research and programming. This involves "learning by doing", that is, integrating elements of evidence gathering and impact evaluation into new interventions from the beginning. WHO and its partners are well positioned to propose a framework for gathering this evidence, particularly to link interventions to intermediate outcomes, and then eventually to long-term health impacts. The Position Paper should also be used as a tool that can help determine a) where we need to strengthen our research efforts and b) where we have sufficient knowledge for the basis of initial programming in the absence of conclusive data. The recommendation stems from the need to work with what we know, while continually seeking to expand the body of knowledge on adolescent pregnancy.

HQ should take a lead in collaboration with ROs develop the strategic outline, including tentative budget, of model programmes on prevention and care of adolescent pregnancy. The research should be an integral part of the programme planning and implementation, with aim to efficiently generate sufficient information to further strengthen program planning and policy making at country level.

4) Continue to strengthen cooperation across relevant departments in order to provide technical assistance and other support for the development and widespread use of high standards in adolescent pregnancy prevention and care.

The advisers present from the Regional Offices noted a need to work with WHO Headquarters, in a coordinated approach across relevant departments, to provide technical assistance and other support for responding to the issue of adolescent pregnancy in countries. This involves working together to ensure the availability of the guidelines/tools on adolescent pregnancy, including developing best standards for adolescent pregnancy prevention and care. It also includes developing joint strategies for linking adolescent pregnancy to achieving MDG 4 and 5, convening strategic consultations, and providing ongoing guidance on developing appropriate indicators and collecting disaggregated data by age.

5) Each stakeholder needs to advance their specific area of the agenda toward effectively addressing and responding to adolescent pregnancy, as initially explored at the meeting and captured in the present report.

Each of the stakeholders represented at the meeting need to advance the actions listed in Section 6.3 (The Roles of Key Stakeholders). Specifically, academics and research institutions need to assist in advancing the missing areas of research they have identified and discussed throughout the review of the Position Paper. The Ministry of Health, Governments, and Service Providers need to ensure legislation is in place to create an overall supportive environment and to work with others to establish joint programmes and approaches to adolescent pregnancy. The WHO needs to form a common agenda for action for adolescent pregnancy at HQ with a clear delineation of responsibilities of contributing departments and to facilitate coordination and collaboration with ROs and partners. Agencies and partners need to continue to share work plans, improve collaborations, and avoid duplications, both at HQ levels and in regional and country level.

6) Upon circulation of the final report, each stakeholder, particularly WHO regional and HQ staff, needs to come up with a set of follow-up actions from the meeting.

There were strong expressions from the majority of participants to hold themselves accountable to the recommendations discussed in the meeting. It was suggested that upon circulation of the meeting's report, MPS and other departments liaise with participants in ensuring next steps to finalizing the position paper, using its findings effectively, and advancing the response to adolescent pregnancy within each stakeholders' niche area of concern and expertise.

The meeting closed with final remarks from Ms. Daisy Mafubelu, Assistant Director-General, Family and Community Health. She noted that adolescent pregnancy exemplifies the importance of working together in the area of overall adolescent development and goes beyond WHO to include other agencies and partners. She acknowledged from the various report-backs that a significant amount of work and consensus building had clearly taken place over the last few days and called on all participants to continue their efforts. She also stressed the importance of working beyond the health sector, for example to reach out to the media and private sector, as well as ensuring that research is not undertaken for the sake of research, but translates into action on the ground.

Her remarks were followed by the circulation a short evaluation form, informal thank-yous, and warm goodbyes.

8. Workshop evaluations

Organizers circulated a short evaluation before the end of the workshop. The 14 responses collected and compiled indicate that, overall, most sessions over the three day meeting were ranked as "very useful" or "useful." A few people found that the lunchtime panel discussion on "Perspectives and Responses of International Agencies and Partners" less useful due to time constraints that did not allow for sufficient interaction and participation. Several of the evaluations stressed the need for follow-up to the meeting and participants' willingness to advance follow-up steps from the meeting. The compiled evaluations are available in Appendix U: Results of Compiled Evaluations.



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