Lessons learned from applying the Accelerated Action for the Health of Adolescents (AA-HA!) guidance for policy development in early adopter countries

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CONTENTS

ACKNOWLEDGEMENTS ii
ABBREVIATIONS iii
EXECUTIVE SUMMARY v
INTRODUCTION vi
Country Background 1
The health situation of adolescents in Barbados 1
Objectives of this report 1
Assumptions about AA-HA! 2
Methods & Materials 2

BARBADOS’ EXPERIENCE IN DEVELOPING THE BARBADOS ADOLESCENT HEALTH STRATEGY (BADHS) USING THE AA-HA! GUIDANCE 3
Overview of the process undertaken to develop the Barbados Adolescent Health Strategy (BADHS)

KEY FINDINGS FROM THE APPLICATION OF THE AA-HA! APPROACH IN BARBADOS 6
1) AA-HA! Understanding gaps in adolescent health issues, and consequent gaps in priority interventions 6
2) AA-HA! - adhering to the evidence-base and setting national priorities 6
3) Applying the AA-HA! ecological approach to programming 6
4) How the Adolescent Health Strategy is being mainstreamed in all Policies Approach (AHiAP) as described in the AA-HA! document 6
5) Political Engagement and Governance 7
6) Generating funding for supporting AA-HA! 7
7) AA-HA! is an enabler to build national capacity 8
8) Adolescent participation 8
9) The National H6 plus UNESCO partnership mobilised by AA-HA! is being maintained 8
10) Setting Monitoring and Evaluation (M&E) framework 8

CONCLUSION AND RECOMMENDATIONS 9
Assumptions about AA-HA! in the context of Barbados’ efforts to develop a national adolescent health strategy 9

REFERENCES 11

ANNEX 1. Comparison between the development process of two policy documents 13
ANNEX 2. List of questionnaires completed/interviews conducted 15
ANNEX 3. Transcript of interviews/questionnaires 16
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<table>
<thead>
<tr>
<th>Abbreviation</th>
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<tr>
<td>AA-HA!</td>
<td>Accelerated Action for the Health of Adolescents</td>
</tr>
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<td>ACGDC</td>
<td>Adolescent and Child Development Clinic</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>BADHS</td>
<td>Barbados Adolescent Health Strategy</td>
</tr>
<tr>
<td>BFPA</td>
<td>Barbados Family Planning Association</td>
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<td>Disability Adjustment Life Years</td>
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<td>GP</td>
<td>Glebe Polyclinic</td>
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<tr>
<td>LA</td>
<td>Landscape Analysis</td>
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<tr>
<td>LGBTQI</td>
<td>Lesbian, Gay, Bi-sexual, Transgender, Queer &amp; Inter-sexual</td>
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<tr>
<td>HFLE</td>
<td>Health and Family Life Education</td>
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<td>National Council of Substance Abuse</td>
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<td>NGO</td>
<td>Non-Governmental Organisation</td>
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<tr>
<td>NAHP</td>
<td>National Adolescent Health Policy</td>
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<td>Abbreviation</td>
<td>Full text</td>
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<tr>
<td>--------------</td>
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<tr>
<td>NNC</td>
<td>National Nutrition Centre</td>
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<tr>
<td>PAHO</td>
<td>Pan American Health Organisation</td>
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<tr>
<td>PAREDOS</td>
<td>Parent Education for Development in Barbados</td>
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<td>Queen Elizabeth Hospital</td>
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<td>Randall Philips Polyclinic</td>
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<td>RBPF</td>
<td>Royal Barbados Police Force</td>
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<tr>
<td>SDG</td>
<td>Sustainable Development Goals</td>
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<td>SHP</td>
<td>School Health Programme</td>
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<td>Senior Medical Officer</td>
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<td>SPPC</td>
<td>St. Philip Polyclinic</td>
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<tr>
<td>SRH</td>
<td>Sexual &amp; Reproductive Health</td>
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<tr>
<td>TWG</td>
<td>Technical Working Group</td>
</tr>
<tr>
<td>T2S</td>
<td>Transition to Secondary School</td>
</tr>
<tr>
<td>WSPC</td>
<td>Winston Scott Polyclinic</td>
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<tr>
<td>UNDP</td>
<td>United Nation Development Programme</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
</tr>
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<td>UNESCO</td>
<td>United Nations Educational, Scientific and Cultural Organisation</td>
</tr>
<tr>
<td>UNFPA</td>
<td>United Nations Population Fund</td>
</tr>
<tr>
<td>VUI</td>
<td>Violence &amp; Unintentional Injury</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td>WB</td>
<td>World Bank</td>
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<td>Youth Advocacy Movement</td>
</tr>
<tr>
<td>YDP</td>
<td>Youth Development Programme</td>
</tr>
<tr>
<td>YES</td>
<td>Youth Entrepreneurship Scheme</td>
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In September 2015, the United Nations Secretary-General launched the Global Strategy for Women’s, Children and Adolescents’ health (2016-2030) in support of the 2030 agenda for Sustainable Development. The Global Strategy envisions a world in which every adolescent realises their rights to physical and mental health and wellbeing, has social and economic opportunities and is able to participate fully in shaping prosperous and sustainable societies.

Building on this momentum and recognising that the SDGs cannot be achieved without investment in adolescent health, Barbados agreed to be an early adopter and embrace the Global Accelerated Action for the Health of Adolescents (AA-HA!) guidance in order to respond more effectively to the health and wellbeing of adolescents.

Barbados’ young people, approximately 55,566 (about one-fifth – 19%) of the total population, are aged between 10-24. Adolescents are critical to the development and productivity of any country, but in Barbados they have no dedicated targeted health services, rather their health care had been subsumed under child and adult care.

However, using the recommendations within the AA-HA! guidance, Barbados embarked on the development of a comprehensive 10-year strategy to engage and respond to the needs of all adolescents, aged 10-19 living on the island. It aims to accomplish this by targeting adolescents who are most at risk and by developing and strengthening the health sector’s integrated response.

The Ministry of Health led the development of the BADHS 2018-2028 using a participatory process and a multi-sectoral approach, guided by human rights principles as suggested in the AA-HA! guidance. Barbados, through two national consultative meetings, regional training, and technical working group meetings, was able to review its indicators and choose interventions appropriate to the region, and in particular, Barbados. Six priority areas were selected for the strategy; 1) positive development; 2) violence, accidents and injury; 3) sexual & reproductive health, including HIV; 4) communicable diseases; 5) non-communicable disease; and 6) mental health, substance use and self-harm. The process took just under 24 months and the implementation of the BADHS is due to be launched in August 2019.
INTRODUCTION

In 2009 PAHO Member States adopted the Adolescent and Youth Regional Strategy and Plan of Action (2010-2018). This was approved under Resolution CD49.R14 (2009) and by 2017, most of PAHO Member States had made good progress in strengthening the adolescent health response under that Plan of Action, with the majority of countries having developed strategic plans, and established national programmes. However, Barbados was not among them, and when the global AA-HA! guidance was launched in 2017, it provided an excellent opportunity for Barbados to apply the guidance and develop a definitive strategy on adolescent health. Barbados therefore became an AA-HA! early-adopter country and the first in the Caribbean to be trained in using the AA-HA! guidance.

Prior to the AA-HA! process commencing Barbados had benefitted from an adolescent health course for doctors, nurses and other adolescent health workers facilitated by the World Bank. Attended by 39 physicians, emphasis was placed on sensitisation to adolescent health and development and adopting a unique interviewing style required to improve adolescent health care interactions. Additionally, 27 public health nurses were given training in adolescent health care while the Barbados Family Planning Association (BFPA) trained doctors, nurses, a social worker, adolescent peer educators and other auxiliary staff to provide adolescent friendly services. Following the workshops and training, the World Bank consultant, Dr. Pemberton-Gaskin, expressed the need for Barbados to continue to implement medical updates, as well as build up a repository of clinical guidelines and best practices in adolescent health.

Country Background

Barbados is the most easterly of Caribbean islands and occupies a total land area of 431 km². and has a tropical climate with temperatures mostly falling within the 20° to 31° Celsius range. Annual rainfall averages 1,254 mm at sea level to 1,650 mm at the highest point, with Barbados recording most of its rainfall during the hurricane season from June – November. The island is vulnerable to hurricanes since it lies in the path of tropical systems that originate off the west coast of the African continent.

Barbados is approximately four hours by air from the major eastern gateways in North America and is eight hours from London, making it a hub for international passenger travel and cargo freight in and out of the region by sea and air. As a consequence, the island is vulnerable to disease vectors and pathogens that can be transferred by people and cargo.

<table>
<thead>
<tr>
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<th>2015</th>
<th>2016</th>
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<tr>
<td>Population Size</td>
<td>276,400</td>
<td>275,400</td>
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<tr>
<td></td>
<td>133.1 M:143.2 F</td>
<td>132.8 M:142.6 F</td>
</tr>
<tr>
<td>Birth Rate</td>
<td>10.4/1000</td>
<td>9.1/1000</td>
</tr>
<tr>
<td>Live Births</td>
<td>2,876</td>
<td>2,522</td>
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<tr>
<td></td>
<td>1,460 M:1,416 F</td>
<td>1,302 M:1,220 F</td>
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<tr>
<td>Population Growth</td>
<td>-0.2%</td>
<td>-0.4%</td>
</tr>
<tr>
<td>Mortality Rate</td>
<td>9.2/1000</td>
<td>9.3/1000</td>
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<tr>
<td>Deaths</td>
<td>2554</td>
<td>2580 (1,275 M: 1,305 F)</td>
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<tr>
<td>Infant Mortality</td>
<td>8/1000</td>
<td>13.5/1000</td>
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<tr>
<td>Infant Deaths</td>
<td>23</td>
<td>34 (21 M, 13 F)</td>
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<tr>
<td>Adolescent Deaths</td>
<td>Unavailable at present</td>
<td>Not disaggregated</td>
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</table>
The health situation of adolescents in Barbados

Of an estimated population of 280,000 in Barbados, approximately 13.5% are adolescents – aged between 10 and 19 years.

Cultural influences, unhealthy diets and physical inactivity predisposes Barbadian adolescents to non-communicable diseases (NDCs), especially obesity and poor nutrition. Over 35% of girls aged between 13 – 15 are overweight or obese, with 36% of adolescent boys and girls in that same age group drinking at least 2 or 3 sugary soda drinks every day. Other NDCs such as asthma, allergic disorders and diabetes are not only common, but difficult to manage in adolescents. In Barbados, some 2,500 children have developed high blood pressure as a result of obesity.

Increasing numbers of adolescents in Barbados engage in risky sexual practices – early initiation, and unprotected sex – leading to early pregnancy and sexually transmitted infections. In 2011 over 12% of births occurred in women aged 19. Most recent school surveys showed that other risky behaviours, such as alcohol, tobacco and drug use, begin before age 14 years. Almost 50% of all adolescent males were involved in one or more fights resulting in injuries over a period of 12 months.

Youth literacy in the 15 to 24-year age group is 98% but access to/knowledge of essential information about health and life-skills appears to be low, and the highest unemployment (47.7%) is between 15 – 19 years, reducing the adolescent’s ability to pay for out of pocket costs for health.

In the absence of a dedicated adolescent health strategy, a number of adolescent health initiatives and activities have been introduced in Barbados, including the following:

1. Development of a National Youth Policy, which was approved by the Cabinet of Barbados in February 2012; this outlines a framework for action on youth development and identifies key strategy areas including the family, core values and lifestyle diseases. One of the goals of the policy is to enable young people to tackle lifestyle diseases, especially HIV/AIDS.

2. The Barbados Family Planning Association provides adolescent services through a Youth Advocacy Movement and a Youth Drop-in Centre. These programmes allow adolescents to participate in peer counselling, educational outreach, and advocacy.

3. The Ministry of Health Draft National Adolescent Health Policy of Barbados (2012/2013), designed to provide a blueprint for comprehensive plans, programmes and services for the adolescent population. The draft policy proposes the following goals:

   - Collect appropriate data to inform the development and revision of relevant policies, laws and programmes;
   - Ensure adolescents have access to appropriate information and comprehensive education and skills training to adequately prepare them for a healthy transition into adulthood;
   - Train adolescents, healthcare workers, teachers and other key stakeholders to promote and administer appropriate healthcare for adolescent;
   - Foster multi-sectoral partnerships among relevant stakeholders to address adolescent needs;
   - Provide health care services that are affordable, acceptable and accessible to all adolescents;
   - Create a safe and supportive environment to facilitate the implementation of health programmes to benefit all male and female adolescents.

As evidenced above, Barbados had already embarked on initiatives to address adolescent health and a number of services and activities had been incorporated in either child or adults’ programmes. However, with the application of AA-HA! guidance, Barbados was able to take the next step and develop a more inclusive comprehensive strategy using a life-course approach that would provide adolescents with the health care and services they needed.

The AA-HA! guidance helped determine six priority areas (called “Clinical Pillars” in the strategy document) including positive development; violence, accidents and injury; sexual & reproductive health (HIV); communicable diseases; non-communicable diseases and mental health, substance use and self-harm.

Two AA-HA! national workshops took place, meetings of the technical working group (TWG), interviews with key informants and a desk review of reports and previous draft strategies, all of which led to the development of the Barbados Adolescent Health Strategy (BADHS) 2018 – 2028.

Objectives of this report

This report documents Barbados’ experience in developing a comprehensive adolescent health strategy in order to assess the relevance and usefulness of AA-HA! guidance, and determine if

modifications are needed to improve the process and content of AA-HA!

A number of assumptions were made regarding the difference AA-HA! guidance could make to policy and strategy development; this case-study aims to measure Barbados’ experience against many of these assumptions, as appropriate.

Assumptions about AA-HA!

1. Using the AA-HA! guidance will lead to a more comprehensive, more evidence-based adolescent health and development strategy and programme plan

2. The comprehensiveness of the AA-HA! guidance across priorities, and the provision of global and regional estimates for deaths and DALYs lost, help national teams to realize gaps in national priorities and data (e.g. for neglected issues such as drowning, mental health, cyber violence), and will lead to a broader strategy and plan than would otherwise have been proposed

3. The provision of the menu of evidence-based interventions within the AA-HA! guidance contributes to a better-informed, more evidence-based policy document (e.g. focusing only on evidence-based approaches)

4. The ecological approach helps to analyse and plan not only based on deaths and DALYs lost but also related to behaviours and health determinants, and to plan interventions at various ecological levels

5. The Adolescent Health in all Policies Approach (AHiAP) described in the AA-HA! document empowers the FMOH to be more effective in bringing together other sectors, and to steer intersectoral efforts, as well as to include actions by other sectors in the resulting strategy and action plan

6. The perceived usefulness of the approach proposed in the AA-HA! guidance and of its recommendations generates the level of political engagement necessary to commit to policy development/review

7. The AA-HA! guidance contributes to a better understanding of the likely benefits from investing in adolescent health, and the national stakeholders are more inclined to fund related activities with domestic and or partner funds (as opposed to asking WHO to pay for expenses related to adolescent health activities)

8. After a brief national capacity building workshop, the AA-HA! guidance is a self-explanatory document that enables the national adolescent health task force team to apply the AA-HA! systematic process independently, without further external support. A facilitator manual based on AA-HA! is important to support this process

9. The existence of the adolescent health module within the One Health Tool (OHT) helps national stakeholders to cost the national implementation plan for the adolescent health programmes

10. AA-HA! contributes to explicitly including actions towards improving adolescent participation in national planning and the resulting adolescent health programmes

11. The H6 + UNESCO partnership brought about by AA-HA! is being maintained at the country level

Methods & Materials

Consultant

The PAHO/WHO contracted a national consultant Mrs. Karen P. Carter, Youth Justice Consultant, with expertise on Youth, Community Safety and Criminology.

Key Informants (refer to Annex 2)

Key informants from the Technical Working Group (TWG), H6 partners, Government Ministries, CSOs, NGOs and related stakeholders were interviewed, or conducted voice recordings

Primary data was collected through interviews with key informants from the MOH, members of the TWG, stakeholders/participants, facilitators and information from the two national consultation workshops to develop the adolescent health strategy, which were held at Accra Beach Resort, Barbados.

Desk review

A desk review of the following documents was undertaken using the assumptions from the AA-HA! guidance.

- Barbados Chief Medical Officer’s Report (2010 – 2012)
- Douglin. C., Draft Situation Analysis (2017)
- Douglin, C., Barbados Adolescent Health Strategy (2018)

Comparisons in process of development of two Strategies (refer to Annex 1)

A comparison was made between the National Adolescent Health Policy (2012) which was drafted and revised in 2013, and the BADHS, which was developed using the Global Accelerated Action for the Health of Adolescents (AA-HA!) guidance, to assess the difference in process and content.
Overview of the process undertaken to develop the Barbados Adolescent Health Strategy (BADHS)

First National Barbados Stakeholders Workshop, Accra Beach Hotel, Barbados
- Presentations /information on AA-HA! by PAHP/WHO:
- Needs Assessment and Landscape Analysis by SMO/MOH.

Regional AA-HA!
The main objective of the workshops was to build regional capacity to use the Global Accelerated Action for the Health of Adolescents (AAHA!) guidance to support countries’ development of national adolescent health strategies and plans.

First Technical Group Meeting – Barbados Ministry of Health, Situation Analysis, MOH.
An expert technical working group (TWG) and contributing multi-sectoral stakeholder team and two consultants were trained to use the AA-HA! guidance in order to develop the necessary adolescent health country documents.

Second Technical Working Group Meeting, Barbados: Review of Situation Analysis, Identify the AH HA! interventions that best fit the gaps identified, SMO MOH, Prioritise the interventions PAHO, Consultant Douglin

TWG Discussion of the Situational Analysis and prioritized interventions/ those already implemented re strengthening/ potential to scale up for programming.

Second Barbados National Workshop:
Presentations /information on situation Analysis and the Draft Adolescent Strategy SMO MOH, Consultant Douglin – main emphasis on finalising the draft of the Barbados Adolescent Health Strategy.

TWG Meeting
MOH incorporated results of the 2nd Stakeholder Meeting. Included recommended M&E Component; Costed the Plan.
Mobilizing political support for a national adolescent health strategy

Since 1990 Barbados has been a signatory to the UN Convention on the Rights of the Child (UNCRC), and the government’s commitment to adolescents/youth is reflected in the Constitution and the National Strategic Plan of Barbados 2006-2025 “Global Excellence–Barbadian Traditions”.

The entire process of using the AA-HA! guidance received the full political commitment of the Minister of Health, the Medical Office Ag. Dr. Kenneth George and Senior Medical Officer Dr. Karen Broome, as well as other staff of the Ministry of Health of Barbados, other Ministries, CSOs, NGOs and academia, who delegated representatives to participate in the process of developing the strategy through two (October 2017, March 2018) national consultative workshops.

Establishing the Technical Working Group (TWG)

The Technical Working Group Meeting was established on October 2017 by Douglin in Barbados where members of the group were trained in AA-HA! guidance in order to develop the necessary adolescent health country documents, and begin work on the Situation Analysis.


Generating funding to support the introduction of AA-HA! in Barbados

Funding for the workshops and TWGs was provided by PAHO.

Inter-sectoral action for adolescent health and strengthening adolescent health and development partnerships at country level

The AA-HA! guidance proposes having both multi- and inter-sectoral action toward adolescent health and notes the importance of engaging adolescents in the development of the national adolescent health strategy, as well as key persons from appropriate sectors and agencies.

The five groups of experts engaged in the process included medical doctors, nurses, a child psychiatrist, a lawyer, academics, a policeman, community development officers, a few representatives from the H6 group of partners and other professionals who work with adolescents. Also included were a few young persons (19 to 24) and two adolescents (10 to 19); in each group one medical doctor was present.

These groups participated in the key informant interviews, both workshops and were included in the meetings held by the TWG.

Participants from outside the health sector included other state mechanisms, CSOs and NGOs as follows:

1. Police Department: represented by their Juvenile Liaison Scheme which conducts outreach, including home visits, counselling, and school programmes.

2. Probation Department: representatives from their adolescent programmes: ASMAN for young males aged 13 – 17; and a Girls’ Circle for the same age group.

3. National Council for Substance Abuse (NCSA) – which conducts education awareness in schools as well as a holistic programme in drug education and life skills.

4. The Bureau of Gender Affairs – which implements programmes for adolescents.

In addition, the following CSOs and NGOs were also involved: the BYS, YAM, YDP – T2S programme, YES, Endless Possibilities, and the National Sports Council Programme. In addition, the A GANAR (Spanish for to earn/win) Programme conducted through the Ministry of Education, D4L and PAREDOS, which works in schools and the community to holistically develop and improve situations for adolescents, students, youth and their families, were included.

October 2017: Participation in the 1st national consultative workshop

The Ministry of Health, in collaboration with the Pan American Health Organisation (PAHO) organised a national workshop for experts and other multi-sectoral stakeholders to receive training using the AA-HA! guidance to support the development of the strategy.

Objectives: Training using the AA-HA! guidance a better understanding of the steps in identifying needs, landscape analysis and prioritisation.

Outcomes: Consensus, capacity building and input regarding the situation analysis.
November 2017: Regional AA-HA! workshop

Overall objectives: To build regional capacity to use the Global Accelerated Action for the Health of Adolescents (AAHA!) guidance to support country level development of national adolescent health strategies and plans.

- Two-day capacity building workshop, 13-14th and morning of 17th November 2017; Objectives:
  1. To build competencies of a regional pool of experts and technical resource persons who could apply the AA-HA! guidance for national priority setting, programming, and monitoring & evaluation.
  2. To plan the 2 days national AA-HA! meeting with larger groups of stakeholders
  3. To field test the initial draft of the AA-HA! facilitators’ guide

- Two-day meeting with national focal points for adolescent health, 15-16 November 2017; Objectives:
  1. Discuss regional and national priorities for programming in adolescent health, based on the AA-HA! guidance
  2. Develop country road maps for the application of the AA-HA! guidance for county-level priority setting, programming, monitoring and evaluation, and costing of a priority package of adolescent health interventions

Outcomes: An expert technical working group (TWG) and contributing multi-sectoral stakeholder team and two consultants were trained to use the AA-HA! guidance to support the development of the necessary adolescent health country documents.

March 2018 Participation in the 2nd national workshop

Objectives: Review the draft situation analysis and integrate into the final BADHS.

Outcomes: Amendments and finalisation of the situation analysis after group discussions/presentations during the second workshop.

Stakeholders were cautioned that for the successful completion of the draft BADHS, other key informants, including representatives from the MoESTI, and students and adolescent groups should have been in attendance. It was agreed that it was vitally important to continue having meetings and updates regarding the strategy until its enactment by government.

Peer Review by WHO and finalization of the strategy

The final strategy was presented to the CMO during a meeting of the TWG. An official launch and endorsement of the BADHS is being considered for August 2019.
KEY FINDINGS FROM THE APPLICATION OF THE AA-HA! APPROACH IN BARBADOS

The following provides an account of the key findings generated from the qualitative analysis of all feedback and data collected.

1) AA-HA! Understanding gaps in adolescent health issues, and consequent gaps in priority interventions

Barbados had already identified many of its national priority issues which were articulated in its National Adolescent Health Policy (2012/13). However, the AA-HA! guidance provided more in-depth analysis, supported by the global and regional deaths and DALYs, which allowed the BADHS to be more comprehensive, focussed, and reduced the number of interventions in the final document. The AA-HA! guidance assisted the TWG in reviewing the situation analysis and prioritising the interventions/programmes best suited to Barbados and the region.

During the first workshop there was much debate regarding the removal of communicable diseases from the list. Due to the number of hurricanes and storms within the Caribbean, and the consequent loss of infrastructure and protection, it was felt the risk of vector borne diseases was high. Available evidence and further discussion concluded that communicable diseases should not be removed from the list of interventions.

2) AA-HA! - adhering to the evidence-base and setting national priorities

This aspect was one of the main strengths of AA-HA! guidance for the majority of the participants. The case studies gave credence to the selected interventions, especially for Barbados and the region, and stakeholders felt comfortable that there was a list to assist them and a matrix which allowed them to rate the information coming from the various groups, helping them to prioritise the main interventions for the strategy.

The deliberations in the group sessions showed how participants weighted different considerations when applying the evidence base to the local context. For example, although there were cases of drowning in Barbados, participants did not consider this a priority for action because cases occurred mostly in summer time when children were on holiday, and participants felt that addressing such cases is less feasible. Also, there were not many cases of adolescent suicide, but there were cases of self-harm, which influenced the group to include this as a priority. (See Table 1).

3) Applying the AA-HA! ecological approach to programming

This approach helps to prioritise the interventions which are feasible and have the potential to be scaled-up. The AA-HA! approach pointed not only to the behaviour of adolescents but the underlying causes/problems which would have an impact on the type of intervention or programmes needed to assist the adolescents. The following actions were prioritised by the NCDs working group to help address obesity in adolescents:

- Nutrition labelling (Food Industry)
- Weight management for obese children (Health, Education and Social services)
- Food based dietary guidelines/Nutrition profile
- Tax incentives on sugar beverages/fats/salt (Fiscal Authority)
- Reduce impact on marketing of fast foods/BCHOP (Marketing, Trades and Standards)
- Control of marketing strategies in schools (Education)
- Campaign – Raise awareness on adolescent obesity Nutrition literacy – guidelines on nutritious foods in schools. (Education)
- Better education – Strengthened nutrition education in HFLE subject, by providing more structure and better penetration of messages. Align Home Economics and PE with objectives of healthy lifestyles. (Education)
- Improve access to healthy foods. (Ministry of Agriculture)

4) How the Adolescent Health Strategy is being mainstreamed in all Policies Approach (AHiAP) as described in the AA-HA! document

Adolescent health has been a component of the NAHP and other health strategies such as the National Youth Policy and the Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH) Strategic Plan 2016-2020.
Participants agreed that the multi-sectoral approach brings a broader, more human and holistic approach to the strategy. To increase buy-in from the relevant sectors, it was recommended that the BADHS is signed-off by permanent secretaries from each Ministry or heads of CSOs to make use of the final BADHS document in their programming. In addition, it should be approved and circulated by MOH for use by all agencies of the inter-sectoral committee.

Furthermore, there were recommendations that the National Adolescent/Youth Policy be completed/revised using the AA-HA! guidance in order to support the enactment of critical legislation which is currently blocking access to health services. Although there is an existing National Youth Policy, the necessary legislation to support adolescent access to health care without first seeking parental consent still has not been enacted. This causes a disconnect for 16-18 youth seeking medical advice or attention and it was proposed that the AA-HA! guidance could prompt further debate and help remove such obstructions.

Although participants agreed that the multi-sectoral approach is crucial, there is no obvious accountability noted in the plan for other actors.

5) Political Engagement and Governance

Senior managers in the MOH expressed pride that Barbados could become the first AA-HA! adopter in the region to successfully establish their national adolescent health strategy. The process had the full support of the Minister of Health.

6) Generating funding for supporting AA-HA!

The MOH has pledged its support for the implementation of the BADHS and it is included in the budget. However, it also indicated that assistance from other sectors, both public and private, would be necessary due the prevailing economic climate. It was suggested that financial assistance would still need to be requested from PAHO/WHO, if not throughout the implementation process, at least in the initial stages.

Costing the implementation plan and mobilising resources

It is proposed to use the one health costing tool to cost the adolescent health strategy, and stakeholders also acknowledged that the implementation would need to involve all sectors. An inter-sectoral committee will be established to oversee implementation of the BADHS, with focal points in each Ministry/agency.

7) AA-HA! is an enabler to build national capacity

Although participants were pleased with the AA-HA! training, they felt that more workshops and additional capacity building would be critical in order to have competent, confident facilitators, and ultimately empower a full complement of staff to implement the final adolescent strategy.

Human resources

As a result of the AA-HA! process, it became evident that although MOH was fully behind the implementation of BADHS, the resources to accomplish the implementation of the strategy were limited and proposals were shared to resolve the situation. Currently, there are no staff dealing specifically with adolescent health, nor is there a specific adolescent health department; adolescents are being addressed/ captured in other areas of health programmes. Senior management proposed that an office to deliver such services be established with a specific plan of action, and that this required an inter-sectoral approach to include all relevant ministries.

It was also proposed that QEH, and the nine (9) polyclinics would be the facilities used to implement the adolescent strategy, and would therefore need an increase in capacity and training at all levels. The CMO and SMO of the MOH indicated that the implementation of the Strategy would take some time before it was established and running smoothly.

Workshops

Lessons learned from the workshops:

- Time management could have been improved with earlier distribution of relevant documents prior to the workshops.
- Some participants felt disadvantaged because they did not receive any of the AA-HA! documents
- Many participants felt the workshops were good but were too “rushed”, as there was much information to share and digest. As a result, they felt uncomfortable trying to accomplish the expected tasks and deliverables.
- Information needed to be more flexible/ appropriate for the region e.g. local and regional data was not representative of the population of Barbados.

Adaptability of the AA-HA!

The majority of the key informants viewed the AA-HA! guidance and methodology as highly adaptable to other strategies and programmes.
It was considered a comprehensive inclusive package, with a step by step structured approach that was effective without further modifications.

They emphasised the importance of having trained personnel and facilitators who can use the AA-HA! guidance. The training of facilitators for Barbados was considered to have been a “crash course” and it may be necessary to have additional workshops/training for all implementation levels, especially the districts, so that everyone is confident and competent to assist with strategy development and implementation.

**Key Informants**

Although most participants agreed to be interviewed, there were a few who were not available (on duty travel/too busy) or did not respond (MOE and adolescents), and others who had inadequate time to complete their interviews.

As a result, the overall response rate to participate in the documentation process was approximately 70%.

Obtaining information back from key informants in a timely manner was also challenging, so the process took longer than expected to be completed. Some members of the TWG were also unable to attend meetings.

**8) Adolescent participation**

No adolescents aged 10 to 19 attended the first national workshop, or the first TWG meeting. However, representatives of the National Youth Programme, Youth Parliament and YAM provided inputs during the second workshop. In addition, there was one adolescent (18 years) who attended the second TWG meeting and shared his experience and views. He recommended initiatives that would best suit adolescents e.g. how gender plays a role in behaviours; how adolescents usually confide in their peers rather than discussing their concerns, health issues with adults – especially their parents. It was felt that it would have been better to have the input of many others in this cohort to better inform some of the decisions/debate.

During a TWG meeting it was noted that there was still no proper representation of this cohort of adolescents at the stakeholders’ meeting. A greater effort was made to resolve this problem and there were two adolescents, one male and one female, in attendance at the final workshop.

While conducting the interviews, some of the interviewees felt strongly that it was detrimental not to have adolescents included throughout the process of the development of the strategy. On the other hand, others insisted that it would be better to include the adolescents later in the process, after the training and examination of data.

**9) The National H6 plus UNESCO partnership mobilised by AA-HA! is being maintained**

Despite significant collaboration with representatives of PAHO/WHO throughout the process, and attendance of UNFPA during the national workshops, none of the other H6 partners were represented at any stage during the development of the strategy.

It was felt that recommendations regarding maintaining the H6 plus UNESCO national partnership were not clearly defined in the AA-HA! guidance. It is also unclear whether the H6 partners were invited for the entire process or not, but attempts were made to include them in the workshops.

However, since the process has now been documented, it was suggested that greater efforts be made to invite key sectors/persons to be on board for the completion of the strategy e.g., MoESTI, and adolescents from focus/youth groups, Youth Parliament, H6 partners and Secondary/Government Industrial Schools.

It was expected that the TWG would be able to have a greater partnership with the H6+ group during the process of finalising the document.

**10) Setting Monitoring and Evaluation (M&E) framework**

Both stakeholders and the TWG agreed that a proper framework for M&E should be applied to the various interventions and will be periodically reviewed for effectiveness and necessary modification of the BADHS Monitoring and Evaluation (M&E) aims to answers questions regarding the progress of programmes. The Global Strategy for Women’s Children and Adolescents’ Health (2016-2030) Indicators and Monitoring and Evaluation Framework (EWEC, 2016) provides comprehensive guidance on indicators that would benefit national adolescent programmes and meet the 17 Global Strategic goals.

It will be important for adolescent health programmes to monitor the full range of indicators, from inputs and outputs, outcomes and impact. These will deal with various queries and be used in different situations. Additionally, there will be youth-led data collection mechanisms to ensure youth involvement in the implementation and the accountability of the Sustainable Development Goals (SDGs).
CONCLUSION AND RECOMMENDATIONS

Over the past year, the training in, and utilisation of the AA-HA! guidance has given all participants a better understanding of suitable health programmes and interventions appropriate for adolescents in Barbados.

The guidance is a powerful tool and has proven, through its evidence base interventions and case studies, that such an approach can be beneficial, not only to the health sector but all sectors and agencies, to assist in the health care and provision of services for adolescents.

For this 10-year strategy to be operational and sustainable, adolescents must be a part of the process. They must not only be given opportunities to voice their ideas/opinions, but be viewed as part of the solution, and be actively involved in the implementation of the BADHS. In fact, it was recommended that all key informants/multi-sectoral group be fully engaged in the 10-year process e.g. the MoESTI and H6+.

Continuous political commitment and accountability for all key sectors are other factors upon which the sustainability and operationalization of the strategy depends. At the time of writing this report, the changes in the MOH put the approval of the strategy on hold, and the mechanisms to make other sectors apply the strategy as a tool in their planning were not clarified.

Assumptions about AA-HA! in the context of Barbados’ efforts to develop a national adolescent health strategy

The AA-HA! guidance with its step-by-step approach led to a more comprehensive, yet precise and well-structured adolescent health and development strategy. It also advised how to properly assess, monitor and evaluate the strategy.

The comprehensiveness of the AA-HA! guidance across priorities, and the provision of global and regional estimates for deaths and DALYs lost, helped national teams to realize gaps in national priorities and data (e.g. for neglected issues such as drowning, mental health, cyber violence), and will lead to a broader strategy and plan than would otherwise have been proposed. However, gaps and duplications still need to be resolved as far as Barbados’ strategy is concerned.

The provision of the menu of evidence-based interventions within the AA-HA! guidance contributed to discussion on the need for more locally applicable interventions, and also helped decision making for what to include in the overall strategy.

The ecological approach helped to analyse and plan not only based on deaths and DALYs lost but also related to behaviours and health determinants, however it is not clear how much of this analysis found its way into the final plan, and at what ecological levels.

The Adolescent Health in all Policies Approach (AHiAP) described in the AA-HA! document further empowered the MOH to bring together other sectors, and to steer intersectoral efforts, as well as to include actions by other sectors in the resulting strategy and action plan. Mechanisms to make other sectors apply the strategy as a tool in their planning will have to be further clarified.

The approach proposed in the AA-HA! guidance reinforced existing political awareness, commitment and engagement and was helpful in supporting policy development/review to develop a more effective strategy. With the changes in the MOH after the strategy was developed, continuity of the political support will need to be ensured to secure the final approval of the strategy.

The benefits of investing in adolescent health were already understood in Barbados, prior to the AA-HA! guidance being applied. However, it is not yet clear if national stakeholders will now be more inclined to fund related activities with domestic and or partner funds, or indeed, how the implementation plan will be funded. Concerns were expressed about the availability of funding and it was suggested that PAHO/WHO will be approached to assist with the initial implementation of the BADHS.

The national capacity building workshops were appreciated, but many voiced concerns that they were too rushed and more time needed to be dedicated to explaining the AA-HA! guidance before the national adolescent health task force team would be able to apply the approach independently. Barbados specified that they would benefit from additional meetings/training/reporting of key informants, stakeholders and the TWG.
It is not clear if the existence of the adolescent health module within the One Health Tool (OHT) helped national stakeholders to make plans for costing the national implementation plan for adolescent health programmes.

AA-HA! contributed to explicitly building awareness and including actions towards improving adolescent participation in national planning and the resulting adolescent health programmes. Barbados’ experience acknowledges adolescent participation was too low, and MOH has stressed their intention to try and improve the participation and involvement of adolescents in the future and involve them in every stage of the strategy (youth groups, students) and review.

The H6 + UNESCO partnership brought about by AA-HA! was not fully appreciated in Barbados and therefore many H6 partners were not engaged. However, the process of documentation has prompted recognition of the potential for strengthening the national partnership to support the implementation of the adolescent strategy, even though the practicality of maintaining a strong national partnership may be challenging.
REFERENCES

Barbados Chief Medical Officer’s Report (2010 – 2012)
Ministry of Health (2013) Draft National Adolescent Health Policy
Recordings from the workshop/meetings
The National Youth Policy of Barbados, October 2011 – Ministry of Family, Culture, Sports and Youth, Division of Family and The National Youth Policy of Barbados, October 2011 – Ministry of Family, Culture, Sports and Youth, Division of Family and Youth
Table 1 – Setting Barbados’ national priorities

<table>
<thead>
<tr>
<th><strong>Key issues discussed in the AA-HA! Section 2</strong></th>
<th>Discussed in the situation analysis</th>
<th>Reflected in selected priorities</th>
<th>Reasons for not prioritising if discussed in the situation analysis</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin Disorders</td>
<td>Yes</td>
<td>No</td>
<td>Low feasibility</td>
</tr>
<tr>
<td>Depression/ Anxiety</td>
<td>Yes</td>
<td>Yes</td>
<td>Under Mental Health</td>
</tr>
<tr>
<td>Road injuries</td>
<td>Yes</td>
<td>Yes</td>
<td>Included Under Violence</td>
</tr>
<tr>
<td>Drowning</td>
<td>Yes</td>
<td>No</td>
<td>Low feasibility – occurs mostly in summer time</td>
</tr>
<tr>
<td>Burns</td>
<td>No</td>
<td>No</td>
<td>Low feasibility</td>
</tr>
<tr>
<td>Interpersonal violence</td>
<td>Yes</td>
<td>Yes</td>
<td>Included Under Violence</td>
</tr>
<tr>
<td>Gang violence</td>
<td>Yes</td>
<td>Yes</td>
<td>Included Under Violence</td>
</tr>
<tr>
<td>AIDS</td>
<td>Yes</td>
<td>Yes</td>
<td>Included Under SRH</td>
</tr>
<tr>
<td>Other STIs</td>
<td>Yes</td>
<td>Yes</td>
<td>Included Under SRH</td>
</tr>
<tr>
<td>Child maltreatment</td>
<td>Yes</td>
<td>Yes</td>
<td>Implied in the strategic objective “To strengthen health and social protection systems to provide services to meet the needs of the most at risk adolescents” Under Violence</td>
</tr>
<tr>
<td>Leukaemia</td>
<td>No</td>
<td>No</td>
<td>Costly</td>
</tr>
<tr>
<td>Cerebrovascular disease &amp; Stroke</td>
<td>No</td>
<td>No</td>
<td>Costly</td>
</tr>
<tr>
<td>Malaria</td>
<td>No</td>
<td>No</td>
<td>Low feasibility</td>
</tr>
<tr>
<td>Lower Respiratory infection</td>
<td>Yes</td>
<td>Yes</td>
<td>Costly</td>
</tr>
<tr>
<td>Meningitis</td>
<td>No</td>
<td>No</td>
<td>Costly. Not explicitly mentioned but one of the key strategy under Communicable diseases is “Getting vaccination to those who need them”</td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>Yes</td>
<td>No</td>
<td>Low feasibility.</td>
</tr>
<tr>
<td>Congenital Anomalies</td>
<td>No</td>
<td>No</td>
<td>Low feasibility</td>
</tr>
<tr>
<td>Anaemia</td>
<td>Yes</td>
<td>Yes</td>
<td>Included Under NCDs</td>
</tr>
</tbody>
</table>

Table 2 – Key areas of adolescents’ health needs assessment – BADHS (2018)

1. Positive Development Interventions
2. Violence Interventions, Accidents and Injury Interventions
3. Sexual and Reproductive Health Interventions, including HIV Interventions
4. Communicable Disease Interventions
5. Non-communicable Disease, Nutrition, and Physical Activity Interventions
6. Mental Health, Substance Use, and Self-Harm Interventions
ANNEX 1. Comparison between the development process of two policy documents

<table>
<thead>
<tr>
<th>Stage in the process</th>
<th>Developing the 2012/13 Adolescent Health Policy*</th>
<th>Developing the Barbados ADH Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity building for the national team/task force to develop the draft</td>
<td>Persons were interviewed but not involved.</td>
<td>Yes – it was a multi-sectoral approach and included the QEH and Polyclinics personnel</td>
</tr>
<tr>
<td>Securing high level commitment</td>
<td>The Ministry of Health</td>
<td>Government Minister of Health, the MOH, public and private sectors</td>
</tr>
<tr>
<td>UN agencies involved in situation analysis</td>
<td>PAHO &amp; UNICEF</td>
<td>PAHO, WHO, UNFPA – during the Workshops and TWG meeting</td>
</tr>
<tr>
<td>UN agencies involved in prioritization</td>
<td>PAHO &amp; UNICEF</td>
<td>PAHO, WHO, UNFPA – at the workshops</td>
</tr>
<tr>
<td>UN agencies involved in producing/revising the drafts</td>
<td>PAHO &amp; UNICEF</td>
<td>PAHO, WHO – during the Workshops and TWG meeting – Dr. Darlene</td>
</tr>
<tr>
<td>Involvement of sectors other than health in situation analysis</td>
<td>MoESTI</td>
<td>MoCSY</td>
</tr>
<tr>
<td>Involvement of sectors other than health in prioritization</td>
<td>MoESTI, MoCSY</td>
<td></td>
</tr>
<tr>
<td>Involvement of sectors other than health in producing/revising the drafts</td>
<td>MoESTI</td>
<td>MoCSY</td>
</tr>
<tr>
<td>Involvement of district level representatives in SA</td>
<td>CSOs, NGOs</td>
<td>A few adolescents, healthcare workers, an Attorney-at-Law, YAM, BARNOD, D4L</td>
</tr>
<tr>
<td>Involvement of district level representatives in prioritisation</td>
<td>NGOs</td>
<td>A few adolescents, healthcare workers, an Attorney-at-Law, YAM, BARNOD, D4L</td>
</tr>
<tr>
<td>Involvement of district level representatives in producing/revising the drafts</td>
<td>NGOs</td>
<td>A few adolescents, healthcare workers, an Attorney-at-Law, YAM, BARNOD, D4L</td>
</tr>
<tr>
<td>Involvement of CSOs, NGOs in situation analysis</td>
<td>NCSA, YAM, D4L, BFPA, GIS, Child Care Board</td>
<td>RBPF, Probation Department, NCSA, BFPA, Government Information Service, Child Care Board,</td>
</tr>
<tr>
<td>Involvement of CSOs in prioritisation</td>
<td>Probation, NCSA, YAM, D4L, BFPA, Government Information Service, Child Care Board</td>
<td>RBPF, Probation Department, NCSA, YAM, D4L, BFPA, Government Information Service, Child Care Board,</td>
</tr>
<tr>
<td>Involvement of CSOs in producing/revising the drafts</td>
<td>Barbados Family Planning Association, Probation, NCSA, YAM, D4L, GIS, CCB</td>
<td>RBPF, Probation Department, NCSA, YAM, D4L, BFPA, Government Information Service, Child Care Board,</td>
</tr>
<tr>
<td>MOH departments involved</td>
<td>MOH, Polyclinics, QEH, Psychiatric Hospital</td>
<td>MOH, Polyclinics, QEH, Psychiatric Hospital</td>
</tr>
<tr>
<td>Lead unit/department</td>
<td>MOH</td>
<td>MOH</td>
</tr>
<tr>
<td>Stage in the process</td>
<td>Developing the 2012/13 Adolescent Health Policy*</td>
<td>Developing the Barbados ADH Strategy</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>-------------------------------------------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td>Adolescent/young people involvement</td>
<td>Adolescents, youth, LGBTQI and UWI – Peer Educator, D4L, YAM</td>
<td>Only two adolescents of the cohort in total, although there were approximately six additional young persons who represented various agencies at the two workshops. One adolescent attended two of the TWG meetings. Information was received from the focus group, they were not involved otherwise.</td>
</tr>
<tr>
<td>Costs of the process</td>
<td>Consultant – $60,000 for training and completion of Policy</td>
<td>Unavailable at present</td>
</tr>
<tr>
<td>Finalising of the Strategy</td>
<td>Has not been finalised - Barbados Family Planning Association</td>
<td>Finalised but pending approval; applicable for a 10 year period – with constant updates, reviews, reporting, meetings when necessary</td>
</tr>
</tbody>
</table>
ANNEX 2. List of questionnaires completed/ interviews conducted

<table>
<thead>
<tr>
<th>Name</th>
<th>Organisation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mark ALLEYNE</td>
<td>National Nutrition Centre – MOH</td>
</tr>
<tr>
<td>Jennifer BAPTISTE</td>
<td>National Council of Substance Abuse</td>
</tr>
<tr>
<td>Vicki BLACKMAN</td>
<td>Eunice Gibson Polyclinic</td>
</tr>
<tr>
<td>Joanne BRATHWAITE</td>
<td>Psychiatric Hospital</td>
</tr>
<tr>
<td>Karen BROOME</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Denise CARTER-TAYLOR</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Alicia CATWELL</td>
<td>Youth Development Programme</td>
</tr>
<tr>
<td>Wilson CLARKE</td>
<td>Royal Barbados Police Force</td>
</tr>
<tr>
<td>Omar EDWARDS</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>Hazel FORDE</td>
<td>Eunice Gibson Polyclinic - MOH</td>
</tr>
<tr>
<td>Shanae GILL</td>
<td>Barbados Family Planning Association</td>
</tr>
<tr>
<td>Alok KUMAR</td>
<td>University of the West Indies – Cave Hill Campus</td>
</tr>
<tr>
<td>Lavonne LOCHAN</td>
<td>Winston Scott Polyclinic</td>
</tr>
<tr>
<td>Monica MARSHALL</td>
<td>Maurice Byer Polyclinic</td>
</tr>
<tr>
<td>Beverley MORGAN-FARRELL</td>
<td>Child Care Board</td>
</tr>
<tr>
<td>Cecelia NEBLETT-MURRAY</td>
<td>National HIV/AIDS Commission</td>
</tr>
<tr>
<td>June PRICE-HUMPHREY</td>
<td>Child Guidance Clinic</td>
</tr>
<tr>
<td>Josette SAM</td>
<td>Child Care Board</td>
</tr>
<tr>
<td>Tristan SNAGG</td>
<td>Youth Advocacy Movement - BFPA</td>
</tr>
<tr>
<td>Deborah THORNHILL</td>
<td>Youth Development Programme - MCSY</td>
</tr>
</tbody>
</table>
ANNEX 3. Transcript of interviews/questionnaires

Forty-five (45) questionnaires were sent to stakeholders and from these twenty (20) were completed. Twelve (12) face to face interviews were conducted and attempts were made to have telephone interviews but due to business work schedules, none were conducted.

The information provided from the 20 questionnaires and interviews showed that approximately 98% knew nothing about AA-HA before the presentations, but after Dr.Baltag’s presentation they felt more enlightened and understood the objectives.

Strengths and weaknesses of AA-HA: The stakeholders felt that the practical step-by-step guidance, the framework and evidence-base provided specifically for adolescents, were key strengths which facilitated the development of Barbados’ Adolescent Strategy. It was also well structured which made it easy to adopt its guidelines. On the other hand, they noted that the AA-HA! required a multidisciplinary approach to tackle adolescent health and the guidance needed to be more tailored to the region and include more local and regional data. The workshops seemed rushed and as a result stakeholders were uncomfortable in trying to achieve the expected goals/tasks. In addition, participants were unable to properly prepare for the group sessions because the AA-HA! documents/information were not circulated in advance. Some stakeholders felt that there would be financial constraints to implementing the Strategy, and assistance would be needed for implementation.

There was a 100% stakeholder agreement regarding a multi-sectoral approach to implementation of the Strategy. They felt:

1. It gives more scope on adolescent issues, reduces overlap and strengthens the programme
2. Reduces the potential for being narrowly focused
3. Discussion and decisions made by several sectors would increase buy-in from all
4. It could bring a human approach especially to the more vulnerable groups
5. Will be able to utilise resources better
6. Ministries usually work in solos, expert knowledge and collaborative efforts are better
7. It was necessary for all stakeholders to be a part of the development process
8. It would bring a better understanding of the problem and a holistic approach to its solution and to the complex health care issues of adolescents.

An interviewee had mixed feelings about the inter-sectoral approach, although she felt that it was better if it had to be championed by a stakeholder/ministry to be achievable.

In contrast, it was felt that having the inter-sectoral approach:

1. Could cause chaos because of stakeholders’ attitudes, dominating behaviour
2. Could become time consuming, thus taking longer to reach consensus, and implementation
3. Could be more difficult to co-ordinate/get participants’ co-operation
4. Agencies could become territorial
5. Data would be centralised

The interviewees felt that the following organisations/persons should have attended the workshops/meetings:

1. MoESTI, a Guidance Counsellor, Social Worker, Principal, Teacher
2. A representative of the Welfare Department, Youth Development Council, Sports, FBO
3. A representative of the PM’s Office, Home Affair, Permanent Secretary, GIS, GIS, Prison

Some of the stakeholders felt that it was unnecessary to have adolescents at this stage of implementation; but other interviewees felt strongly that the main persons missing from the workshops/meetings were the “ADOLESCENTS”. They insisted that there should be no discussion/decisions on this framework without the adolescents’ in-put/buy-in, as they were the “affected” group. Therefore, they felt that at least two students from a Secondary School and Tertiary Institutions and various “youth” organisations should have been present at all meetings.

Additionally, they disagreed that the information shared would have be too technical. Conversely, they felt that the adolescents would be better able to identify and speak to their situations. It was
suggested that too often this groups’ capacity to understand and share is underestimated – it was/is vitally important to get their buy-in in this process. The information shared by the facilitators was a bit lengthy but in most cases was easily understood. There was a concern that not all of them were suited to be facilitators e.g. in dealing with group management/control, knowledge, getting full participation of group members. Many of the facilitators agreed that they did their best with the limited information given on AA-HA!, they too were now trying to fully understand the AA-HA! They admitted the information seemed comprehensive and interesting but the sessions were too rushed. At least another day was needed to properly share the information. The facilitators also felt there should have been a one/two-day workshop with them in preparation for the stakeholders’ workshops. They felt they would have been better informed and have a better knowledge/understanding of the expectations/roles. There were instances when advice was sought to clarify queries from group members/facilitators after the AA-HA! presentation. It was also felt that more support should have been given by the PAHO/WHO facilitators especially before each group session. They should have also spoken to the participants about what was expected in their groups and not leave it solely to the facilitators who may not have been fully comfortable with the material. Before and after AA-HA! the majority of facilitators felt confident in persuading colleagues on the importance of adolescent health; but had no/little confidence facilitating a process of needs assessment, landscape analysis and prioritisation; knowing the evidence-based interventions; identifying key areas for programming/activities and designing a Monitoring and Evaluation Plan. These areas would be addressed going forward. There were three (3) main aspects of the AA-HA! which interviewees felt would get the buy-in of government. These were: Sexual and Reproductive Health, Mental Health or Violence and Unintentional Injury. A few interviewees felt that the government of Barbados would buy-in to all of its components provided the benefits were highlighted and supported by local data. They also perceived that funding, human resources, lack of data, buy-in of decision makers and the ability of the inter-sectoral to come together could be the major challenges/issues in implementing the Plan. One interviewee felt that although it would not be easy to co-ordinate different sectors, it was done for HIV/AIDS, so it could be done for adolescent health. Interviewees felt that their particular areas of expertise/duties within their workplaces could be used to bring awareness to the Adolescent Programme; the following were some of the areas:

1. Merge T2S with aftercare programme
2. Youth Talk – positive lyrics, sounds/music
3. YAM
4. Room 246
5. BFPA Stakeholders
6. Multi-media awareness
7. Increase awareness of Mental Health
8. Strong partnership with other stakeholders
9. Face to face interaction with parents/guardians/Guidance Counsellors/PTA Meetings
10. Have town-hall meetings
11. Share with FBO and within personal church departments
12. Share in Clinics
13. Share and empower adolescents on rights to access health care via public platforms
14. Education awareness campaigns at schools and within communities
15. Research the area of adolescent health to generate good quality local data on adolescent health, and more importantly its widespread dissemination of health care professionals, their trainers, educators and the policymakers from the MOH and other ministries of the relevance by way of presentations and publications.
16. Design a retraining module for health care professionals on adolescent health as part of their continuing professional development.

Attempts to get an interview with the only Attorney-at-Law proved futile for this period, however one interviewee with background in law said that it would be paramount to know policies with right of minors and the relevant information/assistance to challenge parents’ rights to inhibit minors from receiving medical health or things that are beneficial to their wellbeing.

There has been a tremendous amount of information shared regarding the global strategy, AA-HA! on a “group” which is usually overlooked as it relates to access/health/preventative care – the adolescent. Stakeholders felt it was beneficial to them personally and for implementation of the Plan. Many felt it was great to share/network within the groups and various agencies.
When asked what was gained and how they generally feel about the AA-HA! during the workshops, these were some of the findings:

1. More time was definitely needed to fully understand such a comprehensive tool, but apart from this, it was a well-organised, educational and enjoyable experience.

2. A few stakeholders who attended the 1st day workshop were disappointed in not being allowed to attend/be a part of the other workshops/developmental process.

3. Access to information before the workshops would have given a better understanding of AA-HA! and would have eliminated most of the problems experienced, especially the lack of time to adequately deal with group information/presentations.

4. The importance of collaborating with the other agencies in an effort to bring about unification in addressing the various challenges of the adolescent.

5. It is hoped that there would not be too much “red tape” in achieving desired goals/implementation.

6. There could have been surveys and from this a proposed programme before the stakeholders’ workshops.

7. Programmes should be implemented in all schools.

8. Legislation is vitally important for adolescents’ access to services.

9. There is a need to deal with obesity and the foods eaten/given to Barbadian children, from home/kindergarten to tertiary level.


11. Sensitising Staff – greater need for behaviour change rather than developmental change.

12. The implementation of the Strategy would not become a political issue but a health concern, thus protecting “our” future.

13. Gained ideas for inclusion of Adolescent health areas in the medical education and training curriculum.

14. These kinds of workshops should be better organised to facilitate better participation of all stakeholders.

15. The AA-HA’s framework can be followed by all agencies to produce one comprehensive strategy.

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**YOUTH/ADOLESCENT**

“In modern society it is difficult to define “youth/the adolescent.” It is considered one of the most important stages in the human life cycle, simply because it is an age of exploration and any mistakes during one’s youth/adolescence, could cast a long shadow over the rest of one’s life.”

Social scientists have drawn heavily on Erik Erikson’s mapping of psychosocial development stages and depicted youth as spanning Adolescence and Young Adulthood. (E. Erikson 1990)