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Key Issues in the Implementation of Programmes for Adolescent Sexual and Reproductive Health

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This document, unless otherwise indicated, the term "adolescent" follows current WHO convention and refers to any individual aged between 10–19 years. "Very young adolescent" is taken to refer to 10–14 year olds.

The broader term "young person" follows WHO usage and refers to any individual between 10–24 years. However, the term "youth" is used predominantly in the current document in a more generalized sense and does not necessarily correspond with the United Nations definition (i.e., any individual aged between 15–24 years).

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Preface

Over the past five years, significant efforts have been made to identify the major determinants of the outcomes of adolescent sexual and reproductive health (ASRH) interventions, and analysing "what works" in ASRH programming. A growing body of evidence is therefore being generated globally on the important determinants of early sexual initiation, safer sexual behaviours, and other important ASRH issues. A number of meta-reviews of programme effectiveness have been, and are still being, undertaken. However, despite the abundance of descriptions of programme activities, knowledge relating to the implementation of programmes ("what's working") remains limited by a lack of systematic analysis and documentation of programme experience.

At a Working Group meeting on ASRH held in Geneva on 25–26 July 2001, implementation experiences in ASRH were reviewed and a recommendation made that a broader, consultative process be initiated in order to facilitate information sharing and the identification of "Best Practice" as ASRH programmes enter into a new phase. This consultative process is envisaged to consist of four elements:

- creating a global network on ASRH to encourage information sharing and creation of new knowledge on, and knowledge management of, implementation issues
- identifying and addressing key questions and issues relevant to the implementation of ASRH programmes
- establishing an electronic forum for programme implementers to facilitate communication and information exchange
- convening of periodic programme seminars that foster face-to-face interaction, sharing of tools and approaches, and critical thinking about programme implementation.

To assist in this process, the current paper provides an overview of implementation issues in ASRH programming, and raises a number of the key questions and issues which need to be addressed. The review has been based upon the published literature and upon programme reports, curricula and articles on the implementation of ASRH programmes produced since 1996. Insights have also been drawn from discussions with programme managers.

Executive Summary

The Department of Child and Adolescent Health and Development (CAH) is one of the technical departments of the WHO Family and Community Health (FCH) cluster and as such has continued to identify adolescent sexual and reproductive health (ASRH) as a priority area of work. Promoting ASRH has in fact been a central theme in WHO's work to improve the overall health and development of adolescents for the past three decades, with the main objectives being to:

- prevent the early initiation of sex
- promote safer sex when sexual activity starts
- reduce the morbidity and mortality associated with sexual and reproductive activity among adolescents.

There is a now a need for a WHO-wide framework for action in the area of ASRH to provide coherence and direction for current and future activities. This requires among other things a review of past experience in implementing programming aimed at improving ASRH, and the current paper outlines such experience in three broad areas:

1. Responding to adolescent needs and developing innovations
2. Identifying the inputs and processes needed to carry out and sustain successful programmes
3. Expanding the scale and reach of interventions.

Information on each of these areas has been derived from the published and grey literature (including programme reports and training curricula) available since 1996. Key questions for each area have then been raised, with the intention that these can be addressed through an electronic forum and series of seminars, with programme implementers as the primary audience.

1: Responding to adolescent needs and developing innovations

In responding to adolescent needs, programmes need to recognize the diversity of adolescent populations, and segment their intervention programmes accordingly. The issue of gender is crucial, with power differentials being a fundamental element of the relationships that adolescents have with adults and peers alike. While research has pointed to the differences in the socialization of male and female roles, few interventions have attempted to change gender roles or address power differentials in relationships. The few exceptions have demonstrated mixed results, with positive changes for one sex having negative consequences on the attitudes, self-esteem and behaviours of the other. Further attention to gender and sexual relationships should be a priority in ASRH efforts, given that adolescence is a formative period for learning about gender roles and expected behaviours in interacting with the opposite sex. Programmes should foster more open discussions of gender and sexual roles and relationships, refine curricula to address gender differences, and explore new avenues to achieve gender equity.

A range of tools and methodologies are currently being applied to better understand and characterize adolescent needs, and to provide information on the diversity of young people in a given area. Popular approaches include needs assessments; surveys; participatory appraisal techniques; the narrative research method; and assessments of programmes and services. While many programmers and researchers engage in collecting data about adolescents, greater attention to the application of findings is needed for almost all programme types.

As the field of ASRH is relatively recent, innovations that address specific adolescent populations and trends are currently being developed and tested. Innovations should be appropriate for the particular

segment of the youth population; available to those most in need; and affordable and acceptable to young people and the communities in which they live. Examples of innovations in the field include participatory teaching and learning methodologies; interactive media; entertainment education; the use of pharmacies as first point of contact for health service delivery; integrating ASRH interventions into livelihoods programmes; and media advocacy and activism. Many of these innovations have yet to demonstrate effectiveness through rigorous evaluation but have shown promising results in reaching and engaging young people.

2: *Identifying the inputs and processes needed to carry out and sustain successful programmes*

Despite the multitude of reviews on "what works" in ASRH programming, very little attention has been paid to "what's working" or to how successful programmes are implemented. Key questions related to the design, systems functioning and implementation of specific programme types are raised in this section. In the design phase, many programmes have yet to adequately articulate their goals and intended outcomes. One principle of effective behaviour change programmes is that they are based on theory. Tools based on the logic model (such as the one being developed by WHO on mapping adolescent programming and measurement) that enable programmers to explicitly state the theory of change, and facilitate the application of needs assessment findings, can contribute to measurable success.

Political and administrative support is also a core element of successful implementation, particularly in light of the sensitive nature of some ASRH approaches. A number of examples from Latin America illustrate how systems were mobilized to support the widespread adoption of ASRH programme elements, such as sexuality education curricula. In other examples from Asia, support was gained at the pilot project level and once successful, programmes were able to extend this support to reach a broader population. Key questions in gaining political and administrative support are raised at two levels: the *organization* seeking to integrate ASRH programming into its existing operations; and *adult gatekeepers* such as school administrators, employers and policy-makers.

Designing or adapting curricula and educational materials is another common element of programme implementation for most programme types. The primary content of many ASRH curricula is shifting from an emphasis on didactic teaching of anatomy and physiology to more participatory methodologies that emphasize life skills, sexuality and HIV/AIDS prevention. Large-scale programmes in Asia and Africa indicate that adapting curricula requires setting up a consultative process and then tailoring content to the community's specific needs and values. Key questions relate to the core content; review and adaptation processes; and to the pedagogical approaches required to ensure that the major issues are addressed and the necessary information leading to acquisition of skills and modification of attitudes is provided.

Selecting teachers, health personnel, counsellors, peer educators and others working with young people is equally important for the successful implementation of any programme. Adults working with youth programmes must have a solid understanding of young people's needs, and an opportunity to explore their own values and attitudes toward young people and sexuality. Furthermore, due to the shift from didactic to learner-centred approaches, adults working with young people need to be empathetic and skilled in communicating with them. By developing an understanding of young people, adults will create programmes that are respectful of their rights and of their ability to make healthy decisions. Key questions relate to selection criteria; skills; screening processes; definitions of roles and responsibilities; and ongoing support to professionals.

Once selected, programme staff require training and orientation to content, teaching methodologies, activities, referrals and other information provided in a curriculum. Curriculum and training content vary according to who will be delivering the programme: whether teachers of a sexuality-education curriculum; health providers in a service-delivery setting; or young people in a peer-education strategy. Participatory learning and facilitation, in particular, are skills required for most curricula, but the underlying principles may be unfamiliar within many cultural settings. Key questions for training relate

to objectives; training requirements; structure of training processes; and the monitoring and evaluation of skills and competencies.

Finally, management and human-resource systems are essential to effective programme implementation of any type. Integrating ASRH programmes into ongoing operations may pose management challenges, with new roles and functions required by programme staff. Managers undertaking ASRH programmes must assess their own systems, staffing and resource needs in order to ensure programmes are implemented according to plan.

While the processes outlined above are generic to all programme types, specific issues apply to different programme strategies. Programmes that provide information on sexuality and life skills address sexual development, interpersonal relationships, gender roles, body image and reproductive health. Some approaches emphasize HIV/AIDS prevention education, while newer generation approaches integrate life-skills education, HIV/AIDS prevention, and sexuality education. Gender differences have yet to be adequately taken into account in many curricula. Delivering information and life-skills programmes, particularly in school settings, requires going through the processes outlined above. In addition, key questions remain as to when to provide information, how often, and how much; and what skills to emphasize.

Sexual and reproductive health services for young people aspire to be "youth-friendly", assuring access and acceptability, quality and equity in utilization. The greatest barrier to access in most cases is the perception by young clients that they cannot utilize the services. Negative attitudes toward young clients from providers may inhibit access and reinforce perceptions that young people should not receive services. Quality of services refers first and foremost to clinical safety, and to the clarity of information given, as well as responsiveness to the expressed developmental needs of adolescents. To many young clients, however, the nature of the contact and interaction with providers, confidentiality and privacy determine whether or not they use a service again. The COPE approach (EngenderHealth, 2002) and the evolving WHO tool for promoting adolescent-friendly health services, provide frameworks for quality in terms of client rights and staff needs. Standards and guidelines are essential to achieving quality of care, and should be developed within a health system accordingly. Service utilization is influenced by many factors, including cultural models of health-seeking behaviours. A supportive social environment can promote the utilization of services by young people, as can employing a strategy that reaches young people at their first point of contact, such as pharmacies. Key questions relate to elements of an essential package of services for young people; tapping their existing demand for services; modifying provider attitudes and values, and strengthening their counselling and interpersonal communication skills; developing standards and guidelines; and considering service provision in the context of health sector reform.

Involving young people themselves in ASRH programmes gives them a voice to influence the delivery of programmes and services, and builds on the influences that young people have on each other. Most youth involvement occurs in the context of peer education, with the assumption that relationships among young people influence what they learn and how they behave. There is now greater attention given to involving young people in a broader range of decision-making roles. Recruiting young people into programmes, or facilitating their involvement and creation of their own programmes, should take into account the natural social networks and role models in a given network. Young people should be involved in adapting curricula and support materials, developing interpersonal skills, and learning factual information about HIV/AIDS, reproductive health, and gender issues. While young people are actively involved, the responsibilities of programme management still mainly reside with adults. Thus, providing mentoring, supervision and support remain key issues for adult managers of youth programmes.

Multisectoral approaches reinforce the Common Agenda (WHO, UNFPA, UNICEF, 1997) and the WHO Technical Report on programming for adolescent health (WHO, 1999) that call for programmes to provide support for adolescents to receive information, build skills, have access to counselling and health services, and live in a safe and supportive environment. The critical issue for multisectoral programming concerns less the elements of the individual components and more the establishment of the complementary programmes, collaborations and cooperation required to bring about linkages among

components. Partnerships and networks play a crucial role in multisectoral programming. Key questions relate to the added value and benefits of a multisectoral strategy; and to the effective management of partnerships and networks.

3: Expanding the scale and reach of interventions

While there are many pilot programmes for ASRH around the world, few systems deliver them at scale. A number of models for scaling-up and institutionalizing programmes have been described and developed, and processes for expansion proposed. These include organizational expansion, institutionalization, building on existing institutions and infrastructure, diffusion to other systems or through media, influencing policy and gaining commitment and support from leadership. In order to effectively scale-up programmes, institutions need a strategic plan, structures and systems through which to implement programmes; technical and managerial skills; and financial support. The core skills and competencies for programming are proposed in this section. The key issues related to scaling-up and sustaining programmes are resource allocation and mobilization; defining scope and coverage; determining the readiness of an organization to scale-up; and involving young people and community members in planning and implementation.

Sustaining programmes also depends upon a number of considerations, among them government and donor objectives and policies; economic conditions; and well-articulated demand for programmes and services. A sustained programme also requires that institutions have long-term commitments and are well managed. When institutional capacity is strengthened, programmes will more likely continue to function and be operational after the initial start-up period, assuming they receive continued financial support. ASRH programmes face particular challenges in achieving financial sustainability as they are rarely able to generate revenue. Furthermore, young people do not represent a constituency that can influence policies and resource priorities. Thus, sustainability is contingent upon the external environment, institutional commitment, and operational processes.

ASRH programmes are facing greater demands for accountability and impact on youth behaviours by parents, communities and organizations that allocate resources. While the basic elements of these programmes are known, further in-depth examination, discussion and experience-sharing is needed in order to move the field beyond pilot programmes into a phase of expansion and institutionalization. The proposed electronic forum and the discussion points raised in this paper aim to contribute to such a process.

Conclusion

As the field of ASRH matures, further discussion and documentation of programme implementation will be needed if small-scale programmes are to be successfully expanded to reach larger numbers of young people. Such efforts will also be needed if we are to bring about beneficial shifts in resource allocation and in the prioritization of youth programmes in health and education systems, in communities and in workplaces. The issues discussed in this review are intended to provide a starting point for broader consultations with frontline programme staff, programme managers, policy-makers and others interested in improving the well-being and sexual and reproductive health of adolescents.