WHO-EM/CAH/194/E

Report on the

Regional meeting on adolescent health

Beirut, Lebanon
15–17 December 2009

World Health Organization
Regional Office for the Eastern Mediterranean

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CONTENTS

1. INTRODUCTION

A regional meeting on adolescent health was organized by the World Health Organization (WHO) Regional Office for the Eastern Mediterranean from 15 to 17 December 2009 in Beirut, Lebanon. The meeting convened a total of 38 participants, 20 of whom represented delegations of ministries of health from 16 countries of the Region: Afghanistan, Bahrain, Egypt, Islamic Republic of Iran, Iraq, Jordan, Morocco, Oman, Pakistan, Qatar, Somalia, Saudi Arabia, Sudan, Syrian Arab Republic, United Arab Emirates and Yemen; representatives from UNICEF Islamic Republic of Iran country office), the International Planned Parenthood Federation (IPPF) regional and country offices, and the United Nations Relief and Works Agency for Palestine Refugees (UNRWA), Lebanon; field officers; and staff from WHO headquarters, the Regional Office for the Eastern Mediterranean and five country offices. The objectives of the meeting were to:

- review and discuss the adolescent health status in the Region;
- share the regional roadmap for adolescent health with Member States;
- develop country plans of action for adolescent health.

The Eastern Mediterranean Region is a young region, one in every four of its population are adolescents, i.e. between 10 and 19 years old. Adolescence is a critical period of physical, mental, psychosocial transition and of shaping personalities, spiritual and cultural beliefs. While adolescents' health is influenced by a multitude of factors that affect health directly and indirectly, the health sector response is mainly disease-oriented and does not consider those factors in a comprehensive way. Despite the importance of adolescents as pillars for nations' development they have been long neglected by the Member States. The Region is promoting a new comprehensive integrated, evidence-based programmatic approach to address the health needs of adolescents, respecting their multisectoral nature and emphasizing the full participation of adolescents and their families in related interventions.

The meeting took place over three days and included regional and country presentations, discussions, group works and group presentations. This design of the meeting was adopted to ensure interactive discussions and the full participation of the country delegation aiming at obtaining consensus on and creating ownership of the proposed approaches and recommendations. The inaugural session was chaired by Dr Bahij Arbid, Representative of HE Dr Jawad Khalifa, the Minister of Health of Lebanon, Dr Haifa Madi, Director of the Division of Health Promotion and Protection and Dr Suzanne Farhoud, Regional Adviser for Child and Adolescent Health.

2. ADOLESCENT HEALTH IN THE REGION

2.1 Inauguration session of the meeting

Dr Haifa Madi, Director of the Division of Health Promotion and Protection read the opening remarks of Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. Dr Gezairy highlighted the importance of adolescents who constitute about 25% of the population of the Region, however, he noted that they had long been neglected by

many countries despite their importance as assets for development and as pillars for the future of nations. In addition, this period of life was an important transitional phase, a period of change and development of beliefs, norms, behaviours and attitudes. Many factors influenced adolescent health, including economic, sociocultural, demographic and spiritual factors, in addition to globalization, family and political instability and conflicts. Dr Gezairy added that road traffic injuries, adolescent pregnancies, inadequate dietary habits, tobacco smoking and lack of physical activity were among the main health problems of adolescents. Many of those behaviours were major determinants of noncommunicable diseases.

The Regional Office was adopting a comprehensive programmatic approach to address adolescent health promotion and protection, described in the regional road map that highlighted the stepwise and phased approach to address adolescent health. The scarcity of data and information on adolescents' health was a major challenge for efficient planning for adolescent health in order to implement effective interventions. Recognizing the extreme importance of data for sound planning and monitoring, the Regional Office had developed a regional situation analysis tool (SARA) to guide the process of an adolescent health situation analysis in the Region. This step was important to inform evidence-based planning. The Regional Office had conducted a regional adolescent health situation analysis, a mapping for adolescent health programmes and had provided technical support to ministries of health in countries of the Region to establish adolescent health programmes within the structure of the ministry of health. He urged country representatives to adopt the regional approach that respected the multisectoral nature of adolescent health interventions, and ensured the participation of adolescents and their families, in addition to the inclusion of an adolescent health module into relevant surveys and studies to address the issue of data insufficiency.

Dr Arbid delivered the opening remarks of HE Dr Khalifa, Minister of Public Health, Lebanon. Dr Khalifa focused on the importance of adolescents as an important and vulnerable group of the population, representing a period of transition and adoption of behaviours and beliefs that would shape their lives in the future. It was a serious phase of life where there were opportunities for success and stability but also risks of failure and loss in the absence of good guidance and care. Adolescent health was affected by many factors, from family-related factors, such as housing, family stability, economic status, level of education and culture, to the environment-related factors, such as school, and thus the importance of establishing adolescent-friendly schools strongly imposed itself. All of these demonstrated the need to address all health determinants that affected adolescent health promotion which required joint coordinated efforts and persistence from all concerned partners.

The objectives of the meeting and a summary of adolescent health status in the Region were presented by Dr Haifa Madi, Director of Health Promotion and Protection. She emphasized the importance of adolescence as a critical period of age and highlighted some of the health risky behaviours that had an impact of adolescents' health, such as smoking, substance use, lack of compliance to driving safety rules, lack of physical exercise, unhealthy diet and risky sexual behaviour. Those risks had cumulative effects throughout the life course starting from the newborn period to adult life. They affected directly and indirectly the health of adolescents, however, there was a lack of political commitment, lack of institutionalization, inadequate funding, lack of coordination and a scarcity of age- and gender-disaggregated data,

in addition to the fact that adolescent health was addressed by dispersed scattered activities. In response to this situation, the Regional Office was adopting the strategic directions of comprehensiveness and multisectorality and an evidence-based and a culturally-sensitive approach.

4.2 Adolescent health status and achievements in the Region

There are a multitude of factors and determinants that affect adolescent health which justifies the need for multisectoral action to address this issue, including:

- demographic factors: 25% of the population of the Region are adolescents (youth bulge). If they are well guided and exploited well, they can be an asset for development.
- sociocultural factors: the change in family size, structure and stability, the low level of school enrolment, particularly among girls, the inadequate quality of education and gender prevailing norms are major factors among many others that affect adolescent health directly and indirectly.
- low economic status/poverty and unemployment are factors that victimize young people.
- religion is an important factor in the Region; religious advocates have an essential role to play in the spiritual awakening of adolescents.
- sources of information play a major role in shaping opinions and the behaviour of adolescents, particularly the media, travel, peers, the community and family members.
- a situation analysis which revealed that the major killers of adolescents in the Region were road traffic injuries, and adolescent pregnancies which double the risk of maternal mortality. In addition, tobacco use with all its consequences of noncommunicable diseases and cardiovascular affections, the malnutrition forms ranging from under-nutrition to obesity, are among the major adolescent health problems.
- existing laws and policies greatly affect adolescent health promotion and protection directly and indirectly.

Achievements in the Region in the area of adolescent health are addressing a multitude of determinants, the Child and Adolescent Health Programme of the Regional Office has developed a regional road map (Annex 3) that provides the comprehensive phased and stepwise approach to address adolescent health promotion and protection.

The phased approach identifies three phases for action.

- Preparatory phase: the establishment of an adolescent health management structure with a clear mandate (role of the ministry of health as a catalyst and a coordinator for adolescent health, in addition to its essential role in caring for the health of population), preparation of tools and guidelines and identification of the design of adolescent health-friendly services, including criteria.
- Early implementation phase: situation analysis (to demonstrate achievements, gaps and which will result into prioritization of adolescent health issues) and implementation of an initial package in selected geographic areas to learn from the lessons and institutionalize the interventions.

- Expansion phase: based on lessons learnt during the early implementation phase, the expansion concerns the implementation of a full package of interventions implemented with a wider geographic coverage.

The stepwise approach identifies the steps to be followed during different phases: situation analysis (to guide planning process), identification of entry points, implementation, monitoring and evaluation. Adolescent health mapping conducted in the Region showed the absence of an adolescent health management structure within the MOH in many countries, while in some countries adolescent health is dealt with by the school or reproductive health programmes in which adolescent health is not dealt with comprehensively as only a few aspects are addressed.

A regional adolescent health situation analysis was conducted which faced a major challenge of a scarcity of age- and gender-disaggregated data and a lack of adolescent health situation analysis tools. The CAH programme adapted the existing regional CAH/child health situation analysis “guide” to the context of adolescent health needs and developed a situation analysis tool (SARA). It aims to strengthen the country and regional adolescent health baseline data, prioritize adolescent health interventions and guide the planning process for adolescent health. The main elements addressed by this tool are: national, geographic, political, demographic, economic, sociocultural indicators, mortality and morbidity indicators and the programmatic response inside and outside the health sector. The latter addresses how a country responds to adolescent health needs e.g. establishment of a management structure, development of adolescent health plans/strategies/policies, identification of the main adolescent health interventions existing in the country, identification of the main partners, main laws and legislations, incorporation of adolescent health indicators into the information system, mechanisms of supervising adolescent health interventions through the existing supervisory system, etc.

The situation analysis outcome is a report that not only describes the situation but also responds to the question why, so as to explain the determinants behind each indicator. The report should end by identifying adolescent health priorities to be addressed by the concerned programme and interventions. In order to be able to achieve this, the tool suggests a three-phase approach to conduct a situation analysis (Annex 4): task force establishment, preparatory phase, data collection and analysis and finally consensus and official adoption. The tool provides details of conducting each phase, a list of proposed documents that might include data on adolescent health and methodologies to conduct the situation analysis.

The Regional Office has developed a regional concept and approach for adolescent health services. Adolescents require friendly services to provide curative care for the current illnesses they suffer from, to protect them from illnesses in the future and to invest in their health today and tomorrow (curative, preventive and promotive care), to deliver on human rights and to protect important human capital. However, existing health services are mainly disease-oriented, do not respond to adolescent health needs and are not well equipped with qualified staff to deal with adolescents.

While there is not a single menu for the services to be provided in an adolescent health friendly facility, the Region recommends a basic minimum integrated package that includes: growth-monitoring, listening and counselling, clinical care, health clubs (or similar alternatives) to ensure participatory activities of adolescents and possibly entertainment activities (sports, computer laboratories, etc.) (optional).

Adolescent health-friendly services should be located where young people are found. There is not a single model for settings. They can be one or more of the following: adolescent health-0friendly spaces at primary health care level (separate or integrated), at school/university level, at community settings (youth clubs, cultural and social centres, etc.) and at work places. Wherever the entry point is, the mandate is to respond to adolescent health needs and this depends on country set ups, needs and priorities. While planning for those services, countries should consider costs and the potential for replication, expansion and sustainability. Availability, accessibility, acceptability, affordability, ownership, cultural sensitivity, responsiveness to needs, confidentiality, privacy, comprehensiveness and responding to quality norms are the main criteria suggested by the CAH programme for an adolescent health-friendly service. The care providers at those settings can be physicians, nurses, teachers, social workers, psychologists, parents, community leaders, religious advocates and peer adolescents. This depends on the tasks and mandate of those services. The Regional Office suggests standardized steps to establish these services based on a situation analysis to ensure it is evidence based and matches with the regional suggested criteria.

Monitoring and evaluation are essential programme components to support programme managers to track the progress of programmes, decision-making, planning/re-planning and effective use of resources. The health information system is a tool for monitoring and evaluation, however, it is considered as one of the major challenges facing planning for and implementing adolescent health interventions, on one hand because adolescent health interventions are not classical health “disease-oriented” services, therefore, related indicators are not included into the existing routine health information system, and on the other hand adolescent health interventions are multisectoral and many partners share the responsibility of their implementation. For these reasons, no previous attempts were made to gather all partners around the same indicators and even mechanisms for this issue are neither present nor identified. There are different mechanisms for monitoring and evaluation based on the level at which they will be conducted and the types of indicators to be measured. At the level of implementation of interventions, the mechanisms can be information through the routine health information system, regular reporting, supervisory visits, documentation, research, etc., while at the level of behavioural, health and development outcomes, information can be obtained from the health information system and national surveys.

In line of the regional context, at the global level, WHO’s role is to focus on advocating for an approach similar to the regional one: comprehensive, evidence based (needs based) multisectoral approach to strengthen the health sector response to adolescent health. This approach includes a situation analysis based on strategic information in order to inform policies and guide planning and implementation of adolescent health services, while strengthening other sectors to maximize their contribution to adolescent health and

development. This systematic approach is considering the three levels of work: national, district and health facility.

At global level, two main entry points were used by WHO to work for adolescent health, namely HIV/AIDS and prevention of adolescent pregnancy and its unfavourable outcomes. In the future, more entry points will be also considered, namely promoting healthy nutrition, substance use, mental health and injuries. The Regional Office is working towards a coherent approach to adolescent health across different WHO programmes.

3. COUNTRY PRESENTATIONS

3.1 Morocco

Morocco adopts the WHO definition of adolescents as those aged between 10 and 19 years. Young people represent 33% of the population of the country. The situation analysis conducted in 2003 revealed that the major problems of adolescents include: the high rate of illiteracy, especially among girls, unemployment, increase in the age of marriage, reduced family role and lack of information/communication with their communities. Health programmes did not specifically target adolescents' needs and the Ministry of Health did not have a structure to address adolescent health. Moreover, the design and mandate of existing services—either within the health system or at schools and universities—were not meant to respond to adolescent health promotive and preventive care and there were no adolescent health-friendly services. The existing infrastructure that offered leisure activities for youth and adolescents was insufficient.

To respond to those gaps, a multisectoral approach was adopted in 2004 "youth–youth" and implementation of a pilot of youth-friendly spaces started. The framework of the youth–youth project aimed at improvement of the psycho-social development of adolescents and youth between 12 and 25 years of age and included a health component. Currently, 23 youth-friendly spaces are functioning and 12 are under development as part of primary health care. These are distributed all over the country in the capital cities of the regions and provinces. The spaces offer services that respond to youth and adolescent needs: medical services, listening and counselling services and animation sessions where the adolescents actively participate in discussion of different health topics of interest. The protocol of those spaces ensures a participatory approach of youth and adolescents in service delivery and follow-up.

Guidelines for the functioning adolescent health-friendly services were developed and the Ministry of Health built the capacity of the staff working in those spaces accordingly.

However, this experience revealed some challenges, namely the lack of certain specialties of care providers, such as psychologists and social workers, lack of financial resources, limited package (does not include important elements such as nutrition counselling, counselling on smoking cessation, etc.), limited coverage of the population by those services, insufficient integration of adolescent health components into the health programmes, lack of

linkages to other existing interventions that address youth and adolescents and low access due to inappropriate working hours.

The next steps suggested to move forward the adolescent health agenda are: a) institutionalization of an adolescent health programme; b) conduct of a national adolescent health situation analysis using the regional SARA tool; c) finalization of the national strategy on adolescents and the involvement of different partners in this strategy; d) evaluation of youth-friendly spaces, development of standardized guidelines; e) capacity-building of the staff on the new guidelines; e) based on the results of this evaluation: expansion of implementation of youth-friendly services to cover a bigger proportion of young people; and f) introduction of adolescent health into the teaching curriculum of medical and other health allied professional schools.

3.2 Yemen

Yemen also adopts WHO's definition of adolescence. Adolescents constitute about 29% of the population. The low literacy rate, the high rate of adolescent pregnancy, the low economic status, the high rates of substance and tobacco use, the prevalence of different forms of malnutrition, especially under-nutrition and stunting, the low physical activity rates and the prevalence of injury and violence are the major health problems for adolescents as identified by the different surveys conducted in the country. A few scattered activities, not reflected in an integrated national plan for adolescents, were the sole activities to address those issues. In 2009, an adolescent health programme was established by a ministerial decree that stated the mandate of the programme as well as its placement under the child and adolescent programme/primary health care department. A programme director was nominated by the ministerial decree. The future steps for adolescent health in the country include: conducting a situation analysis, incorporating an adolescent health module in the upcoming demographic health survey, development of a policy paper and strategic directions based on the evidence brought by the analysis and the survey; and the development of an integrated plan for adolescent health activities ensuring the coordination mechanisms with governmental and nongovernmental sectors.

3.3 Bahrain

Bahrain also adopts the WHO definition of adolescents. In Bahrain, young people constitute 32% of the population. The available information shows that nutrition (anaemia and obesity), tobacco smoking, physical activity, road traffic injuries are the main adolescent health problems in the country. The country enjoys a good network of primary health care facilities, with high access of the population and community participation. There is a good school health service. A national youth strategy was developed and a school health programme was initiated, in addition to the establishment of a social centre. A pilot adolescent health clinic was launched in one primary health care facility. In addition, some community activities in partnership with community and scattered awareness-raising activities were conducted, particularly in the areas of HIV/AIDS, reproductive health (premarital counselling), nutrition, oral health, etc. However, the interventions are still scattered and uncoordinated and require a vision of a comprehensive and integrated approach.

Currently, the country is in a preparatory process for the development of an adolescent health programme. The mandate of this programme was drafted, the placement of the programme under primary health care/public health department was decided, and an adolescent health programme coordinator was selected.

The future actions to move this process forward include:

- official endorsement of the adolescent health programme, official formulation of an adolescent health coordination committee chaired by the undersecretary for primary care and public health that respects in its structure the multisectoral nature of adolescent health;
- conduct of an adolescent health situation analysis as a first step using the regional SARA tool;
- adaptation of the regional adolescent health package to the national context;
- pilot-testing the adolescent health interventions and services at different settings;
- strengthening the database and information system.

The Ministry Of Health of Bahrain is planning also to play a role in advocating for the Regional Office adolescent health comprehensive approach at the subregional Gulf Cooperation Council (GCC) level.

4. GROUP WORK: INSTITUTIONALIZATION OF ADOLESCENT HEALTH WITHIN THE MINISTRY OF HEALTH STRUCTURE BASED ON EVIDENCE

The participants were divided into two groups (A and B) and three group works were conducted. Each group prepared a presentation which was presented and discussed in a plenary session held after the group work. The overall objective of the group work was to discuss in-depth some important topics with relation to adolescent health and to reach general consensus among participants.

4.1 Group work 1: Institutionalization of a comprehensive adolescent health programmatic approach in Member States of the Region

The objectives of this group work were to discuss and obtain consensus (adoption) on the strategic framework for action on the adolescent health programme mandate and guiding principles. Discussions revealed that countries of the Region are at different phases and forms in terms of the establishment of an adolescent health management structure. There was a consensus among participants of the two groups on the regional vision on the need to have a management structure for adolescent health supported by evidence, which will differ in form and mandate among different countries according to the situation and target.

A consensus was obtained on the proposed mandate for the adolescent health structure which "w*ould assume the leadership and stewardship role and responsibility to improve health of adolescent (10–19 years of age) health through promotive, preventive and curative approaches ensuring a continuum of care"* should be based on the following golden

principles: a) an official endorsement of the structure to ensure high-level commitment and resource allocation and consequently ensuring institutionalization and sustainability, coordination among partners; b) planning should be based on evidence through the conduct of a situation analysis; c) adoption of a multisectoral and participatory approach; d) development of a set of indicators and clear plans for monitoring and evaluation and the establishment of mechanisms for regular data collection; and e) development and implementation of a package delivered at facility and other settings, including community-based approaches. The adolescent health structure should involve key players to ensure comprehensiveness and integration. It should provide consideration to gender sensitivity.

The steps proposed by the Child and Adolescent Health Programme of the Regional Office to establish this structure were fully endorsed by the meeting. The first step agreed upon is providing evidence to policy-makers, which will lead to identification of the mandate of the management structure, identification of priorities, development of guidelines, identification of entry points to deliver services and planning for the adolescent health programme (including plans for monitoring and evaluation).

While recognizing the multisectoral nature of adolescent health needs, it is essential to identify the role of the ministry of health in this area. Participants agreed that the ministry of health should assume the role of leadership among different partners to advocate for adolescent health, to provide evidence, to mobilize other sectors and resources, to facilitate the process of planning, to guide (provide technical support), develop guidelines and packages for interventions, monitor and evaluate the implementation of adolescent health interventions and finally to coordinate the movement for adolescent health in the country among different partners.

4.2 Second group work: Approaches and requirements for country adolescent health situation analysis (SARA)

Participants described the importance of the adolescent health situation analysis as an essential step for describing and analysing the current situation in order to identify issues, gaps and priorities, to guide the planning process based on evidence, to provide a baseline that enables monitoring and measuring progress and to serve as an advocacy tool to obtain political commitment to the case of adolescents. The possibility of using data of the situation analysis to compare indicators between countries with similar context is another added value of the situation analysis.

The problem of the reliability of sources and consistency of data from different sources was raised and this is the reason why it was suggested to introduce a standardized adolescent health module into existing surveys, such as the Pan Arab Project for Family Health (APFAM), demographic health surveys and multiple indicator cluster surveys, and to insert age disaggregated data/indicators on adolescents in the existing health information system.

A general agreement on the usefulness and comprehensive of the Regional Office SARA tool content, sections, proposed steps, reference and methodology was obtained. The meeting recommended the quick finalization of this tool after considering an expansion of

some sections of the tool was proposed such as: details in the section of health system structure, addition of immunization indicators (hepatitis, rubella, etc.), a health care financing section (if feasible) or at least budgeted costs of the national plan for adolescent health, addition of an indicator of the impact of multi-cultural environment on adolescents' health and behaviour to the section of sociocultural indicators. The Regional Office should accelerate the process of finalization of this tool for use by countries as a first step towards moving forward the adolescent health agenda. Some additions were suggested for the section of methodology of SARA conduct, namely involvement of adolescents in the exercise. In addition, it should provide more details on the expected outcome of the exercise and highlight the importance of advocacy all through the process of situation analysis.

The third group work focused on the adolescent health-friendly services. Those services can be delivered through different settings. There is not a single model to be adopted by all countries, but a country can adopt one or more of the prototypes proposed by the region. What is essential is to make sure that those services meet the criteria of feasibility, practicability, cultural sensitivity, comprehensiveness, sustainability, effectiveness, efficiency, confidentiality and privacy. The decision on the model of those services should be based on evidence and the identification of needs and should deliver a comprehensive package that responds to those needs.

The meeting agreed on a basic standard package of services that would include growth-monitoring, listening and counselling, animated sessions (health clubs) to discuss in an interactive way, different health-related issues by and with adolescents and of course clinical care (general and specialized). An optional component is to facilitate the conduct of useful entertainment activities according to the resources and space available (sports, computer laboratory, etc.).

Countries would adopt different approaches and options for establishing adolescent health-friendly structures according to the context and needs (Annex 5).

The last session of the meeting was dedicated to the development of adolescent health country plans using a template prepared by the Child and Adolescent Health Programme of the Regional Office and staff provided technical support to guide the process of planning during this session.

During the closing session, the following conclusions and recommendations of the meeting were presented, discussed and agreed upon by all participants.

5. CONCLUSIONS

Representatives of countries in the Region participating in the meeting:

- adopted the regional road map as a guidance to the implementation of a comprehensive approach to adolescent health in the Region.
- acknowledged the need to an adolescent health management structure which assumes the leadership role of ministry of health in promoting adolescent health.
- reached a consensus on the value of the regional tool for situation analysis (SARA) to guide the process of analysing the adolescent health situation in the countries.
- placed the situation analysis as a bench mark to provide evidence and guide action for adolescent health.
- agreed on the relevance and importance of establishing adolescent-friendly services at different entry points selected and agreed upon according to the country context.
- recognized the lack of age and gender disaggregated data on adolescent health within the health information systems and survey tools.
- recognized the need to develop a multisectoral plan for adolescent health to which all concerned partners contribute to reach the national target (s).
- welcomed and endorsed the regional vision, approach and tools for adolescent health.
- acknowledged the value of WHO technical support throughout the work for adolescent health.

6. RECOMMENDATIONS

To Member States

1. Initiate the process of official establishment of an adolescent health management structure in line with the agreed-upon mandate.
2. Share with the Regional Office existing adolescent health-related documents and studies to enable the Regional Office to finalize the regional situation analysis report.
3. Prioritize the conduct of adolescent health SARA and/or update the existing adolescent health situation analysis report, in consultation with the Regional Office as a first step to start action for adolescent health.
4. Consider the results of SARA in advocating, planning and selecting elements of the package and entry points for services, etc.
5. Undertake efforts to introduce adolescent health indicators into the routine health information system and an adolescent health module into the existing surveys, such as the Pan Arab Project for Family Health, demographic health surveys, multiple indicator cluster surveys, etc.
6. Implement the plans of action developed during the meeting and provide quarterly feedback on their progress to the Child and Adolescent Health Programme of the WHO Regional Office.
7. Make efforts to identify available potential interested donors in their own countries for resource mobilization.

To WHO Regional Office

8. Finalize the SARA tool and share it with countries.
9. Develop adolescent health regional generic guidelines based on the results of situation analysis.
10. Make efforts to assist countries in mobilizing resources to support adolescent health in the Region
11. Follow closely the implementation of the plans of action and provide feedback.
12. Assist countries to introduce national adolescent health guidelines into the curriculum of basic education in collaboration with ministries of education and higher education.
13. Update the adolescent health mapping, based on the information provided by the countries.
14. Continue providing required technical support to countries.
15. Collaborate with concerned partners, mainly UNICEF, IPPF and UNRWA and others to move the adolescent health agenda forward.

Annex 1

PROGRAMME

Tuesday, 15 December 2009

08:30–09:00 Registration

Session 1: Inauguration Session

09:00–10:30 Regional Director's Message
Minister of Health/Lebanon Speech
Objectives of the Meeting, DHP
Adoption of the agenda
Introduction of participants
Election of officers
Adolescent health programme in EMRO: RA/CAH

Session 2: Institutionalization of a comprehensive Adolescent Health Programmatic approach in Eastern Mediterranean Member States

11:00–13:30 **Group work 1: Discussion of the regional framework for action and adolescent health programme mandate and guiding principles**
Introductory presentation
Group work
Group plenary presentations and discussions

14:30–15:30 **Country experiences**:
- Lessons learnt from a comprehensive adolescent health programme, **Morocco**
- Creation of an adolescent health programme, **Yemen**
- Establishment of an adolescent health programme, **Bahrain**

Discussions

15:30–16:00 **Regional adolescent health situation analysis: MO/ADH**
Discussion

16:00–17:00 **Group work 2: Approaches and requirements for country adolescent health situation analysis**
Introductory presentation
Group work

Wednesday 16 December 2009

09:00–10:30 **Group work 2: Approaches and requirements for country adolescent health situation analysis (Cont.)**
Group work
Group plenary presentations and discussions

Session 3: Steps to plan and implement an ADH programme:

11:00–11:30 **Establishment of ADH friendly structures at different entry points: RA/CAH**

11:30–13:00	**Group work 3: Options to establish ADH friendly structures** Introductory presentation Group work Group plenary presentations
13:00–13:30	**ADH package: Current developmental work in the Region: MO/CAH** Discussions
15:00–16:30	**Group work 4: Adolescent health indicators and regular information system** Introductory presentation Group work Group plenary presentations
16:30–17:00	**WHO's role in promoting and advocating for adolescent health and development, CAH/HQ** Discussion
17:00–17:30	**Adolescent Health Strategy: UNICEF/MENARO** Discussion

Thursday 17 December 2009

Session 4: Planning for adolescent health at country level

08:30–08:45	**Presentation: Steps of planning for early phase, RA/CAH**
08:45–12:00	**Group work 5: Development of plans of action**
13:00–14:00	**Conclusions and recommendations**

Annex 2

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Table 1. Adolescent future leaders: working for them and with them

I. Management structure	**Regional Office** Responsible unit: CAH unit Staff: RA/CAH, MO/CAH		**WHO Country office** Responsible focal point	**Country level** 1. Mandate 2. Placement 3. Official establishment	
II. Mandate of the ADH programme	Promotion of adolescent health safety and development addressing the population of 10–19 years old within and outside schools adopting a life cycle approach (continuum of care) ..				
III. Approach	**Phased and stepwise approach**				
III.a Phased approach	**Preparatory phase**		**Early implementation phase**	**Expansion phase**	
	- Conduct of situation analysis and identification of priorities - Identification and of levels of work and care providers - Identification of package component - Development of package		- Early implementation package (limited selected priorities) - Selected geographic areas	Scaling up the implementation: - Full package - Wider geographical coverage to reach the targeted population	
III. Approach	**Phased and stepwise approach**				
III.b. Stepwise approach	**1. Situation analysis**	**2. Identification of levels of action, priority settings and targeted providers**	**3. Package/ tools development**	**4. Orientation and planning**	**5. Implementation, monitoring and evaluation**
	-Describe ADH profile -Identify common problems and issues -Describe efforts for ADH -Identify priorities for interventions	These are decided based on the priorities identified during SA	-Advocacy - Orientation -Situation analysis - Training guidelines -Monitoring & evaluation -Health information system	- For Policy making &partners: -Programme managers -concerned staff at national level: -Peripheral/ district concerned staff	-National Planning ---Adaptation and pilot testing of package & tools -Capacity building in package delivery -Implementation -Monitoring & evaluation
III. Approach	**Phased and stepwise approach**				
Stepwise approach	**III.b.2 Levels of action**				
POLICY-MAKERS and PARTNERS	**PACKAGE DELIVERY (Adolescent Health Friendly Services: AFS)**			**BASIC EDUCATION**	
	Primary health care	**Schools, universities, Occupational health facilities**	**Community**	**Elementary education**	**Higher education**
•Advocacy to: - Create enabling environment - Ensure understanding of ADH needs Endorsement of policies and decisions •Strategic planning •Endorsement of national plans of action	- Setting criteria for AFS - Establishment of services and implementation of the package	- Setting criteria for AFS establishment - Implementation of the package	Adolescents gatherings such as clubs and other community settings through a participatory approach, media	Incorporation into teaching curricula of schools (sciences, biology, social behaviours, etc.)	Introduction of the package into teaching curricula of universities particularly medical, paramedical, teachers, religious advocates and information. Package should be tailored.

Annex 4

STEPS TO CONDUCT SARA

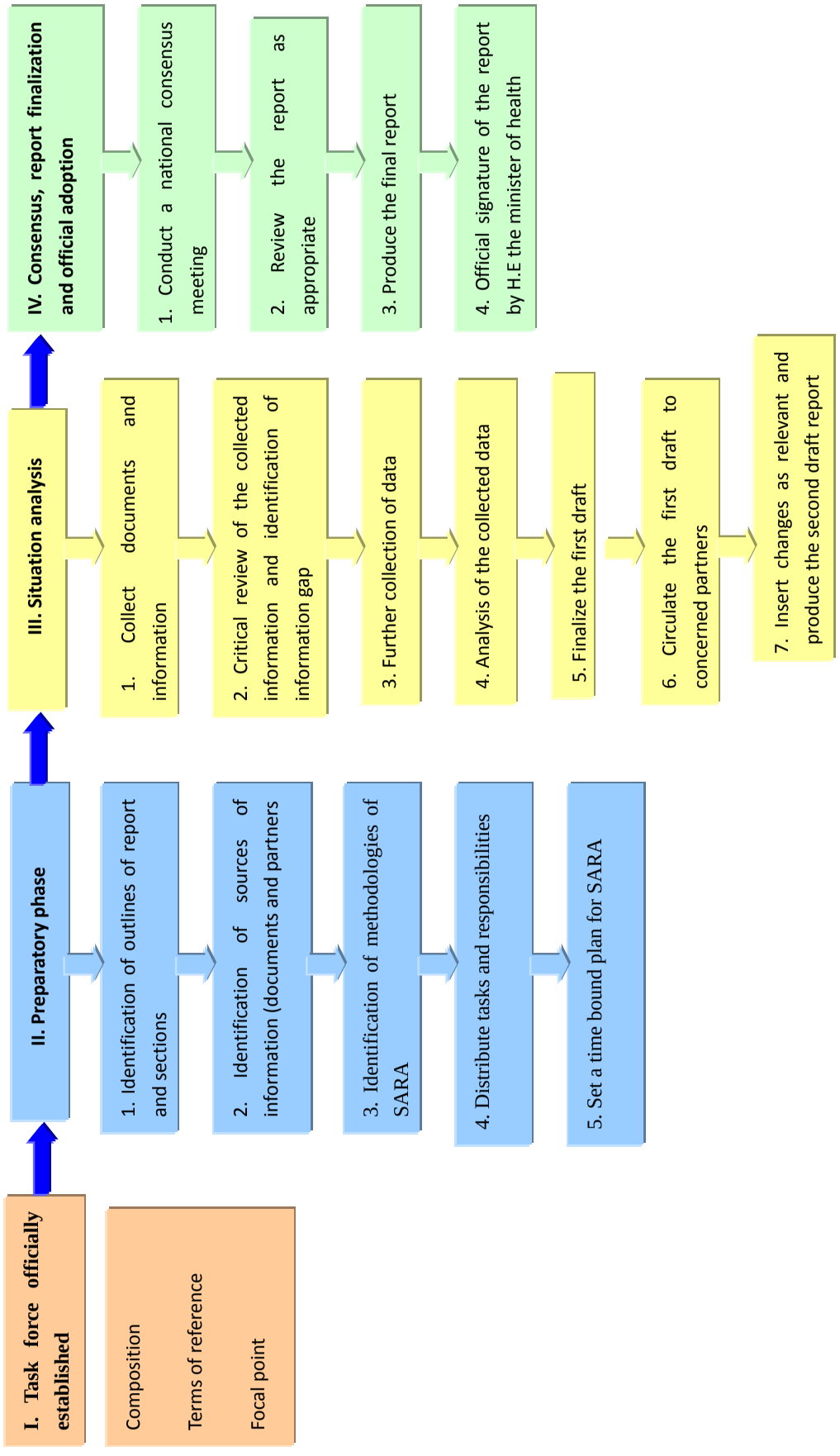

Figure 1. Schema of the process of adolescent health situation analysis and response (SARA)

Annex 5

COUNTRY OPTIONS FOR AHFS

Country	Entry point	Package	Phased approach	Stepwise approach
Saudi Arabia	- Primary health care (PHC)-integrated, hospitals (early phase), youth clubs, NGOs	Promotion, prevention and curative	Preparatory phase Pilot phase first	Adopting steps suggested by the Region
Qatar	PHC-integrated, youth centres, NGO structures, school, religious places - Part of one plan	Comprehensive	Yes Pilot phase	Adopting steps suggested by the Region
Yemen	Mainly community settings Integrated into PHC Schools, religious places (for face to face), outreach activities, youth camps, introduction into curriculum	Promotive, preventive, curative	Pilot (selection according to geographical situation, demograhic factors)	Adopting regional steps proposed
Sudan	Variable culture, in some areas, AFHS might be stigmatized (religious places, media). More acceptable if linked to PHC, schools, in conflict areas (NGO structures). Community-based approaches (CBI and UNICEF projects)	Promotive, preventive, curative	Mapping existing and resources as per SARA and identified priorities and packages	
Afghanistan	Counselling centre run be youth under supervision of PHC, health facilities under basic package of health services. School health initiative.	Promotive, preventive Reproductive health services for married couples	Youth centres (UNFPA)	Afghanistan Family Planning Association health centres
Morocco	Youth health-friendly spaces Integrate to PHC (reception, medical service, all non sensitive issues, orientation service). Schools and university services, introduction of new community approaches, e.g. peer education and parental education at community settings Strengthening existing structures in ADH-friendly services	Comprehensive	Expansion	

Egypt	Integrate into PHC centres, School health and NGO structures Introduce into curriculum of PHC physicians	Comprehensive	Pilot (geographic representation	Adopted the steps proposed by the Region
UAE	School health (preventive and promotion) Integrated into PHC (curative care), use technology and media to advocate for the services (blackberry) Big issue: access of expatriates to PHC	Comprehensive Establish linkages?	Pilot	Adopted the steps proposed by the Region
Oman	Integrate them into PHC, web site and hotline for adolescents	Comprehensive	Start at national level	
Jordan	Integrate into PHC that includes counselling centres, use the hotline of AIDS, schools peer to peer education	Comprehensive	Pilot at five centres	
Bahrain	Integrate PHC services School health centres Expand to university centres Community outreach mobile activities during weekend, religious places, IT site, adolescent clinics, youth clinics	Comprehensive	Pilot	Steps proposed by the Region
Iraq	Integrated into PHC School health Community (LADP) intervention	Comprehensive	Pilot	Regional approach
Iran	Broaden the scope of adolescent health-friendly services from HIV to other priorities Integrate into PHC Outreach by young people	Comprehensive	Expansion of both content and structures	

Lebanon	Strengthen PHC structure	Adolescent structures, e.g. clubs	NGO facilities	Social affair facilities
UNRWA	PHC facilities	School health	NGO services in refugee camps	
Somalia	PHC services facilities	UNFPA-supported youth-friendly health services facility	Internally displaced persons camps supported by NGOs and UN agencies	Red Crescent/Cross