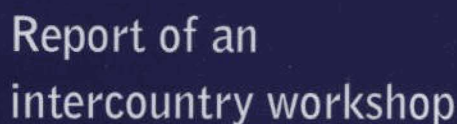
WHO-EM/WRH/042/E

Adolescent peer education in formal and non-formal settings



Report of an intercountry workshop

Monastir, Tunisia
6–9 December 2004

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1. Introduction

The WHO Regional Office for the Eastern Mediterranean held an Intercountry Workshop on Adolescent Peer Education in Formal and Non-formal Settings in Monastir, Tunisia, from 6 to 9 December 2004. The workshop was attended by 16 experts from ministries of health and education, and staff from the United Nations Children's Fund (UNICEF), United Nations Relief and Works Agency for Palestinian Refugees in the Near East (UNWRA), International Planned Parenthood Federation (IPPF) and the International Federation of Medical Students' Associations (IFMSA), in addition to WHO staff members. WHO Temporary Advisers came from Bahrain, Egypt, Iraq, Jordan, Lebanon, Morocco, Oman, Saudi Arabia, Tunisia and Yemen. The objectives of the workshop were to:

- review, share and document success stories in the field of adolescent peer education in formal and non-formal settings;
- elaborate guidelines to promote adolescent peer education activities in the field of research, capacity building, follow-up and evaluation; and
- determine adolescent health education topics by age groups, settings and links with health services.

On behalf of His Excellency Dr Ridha Kechride, Minister of Public Health, the workshop was inaugurated by Dr Hichem Abdessalem, Director General, Technical Cooperation Unit, Ministry of Public Health, Tunisia. Dr Abdessalem welcomed the participants and expressed his gratitude to the Regional Office for holding this important activity in Monastir. He raised priority issues that were believed to be required for promoting adolescent health and development through peer education approach. He added that this approach was

considered to be an effective means for providing appropriate information to guide young people to responsible behaviours. Dr Abdessalem assured the participants of the commitment of the national authorities to the implementation of relevant global policies and programmes in Tunisia.

Dr Ibrahim Abdelrahim, WHO Representative, Tunisia, delivered a message from Dr Hussein A. Gezairy, WHO Regional Director for the Eastern Mediterranean. In his message, Dr Gezairy stated that the workshop was an outgrowth of the successful intercountry workshop with partners on promoting adolescent health and development using information, education and communication, which was held in Amman, Jordan, from 6 to 9 May 2002. It was a result of fruitful integrative efforts that emphasized the interactive relationship between adolescent health and development and the required supportive health education and school health interventions. The rapidly changing socioeconomic circumstances in countries of the Region posed considerable challenges for young people to make a safe transition into adulthood by adopting healthy behaviours and resisting risk factors. Many unhealthy practices such as smoking, risky sexual behaviour and alcohol and drug addiction had their roots in adolescence. Preventing risky behaviour and promoting healthy choices among adolescents, in particular, resulted in positive health outcomes, not just during adolescence, but also during adulthood. Therefore adolescence was considered a gateway to health promotion. Well-developed adolescents who were empowered with appropriate life skills, had a better chance of becoming healthy, responsible and productive adults, leading to better potentials for leading successful careers, and increased productivity and progress. In 1996, the Forty-third Session of the Regional Committee for the Eastern Mediterranean issued a resolution on the health education of adolescents which underlined the importance of adolescence as the critical decade of human life and stressed the need to implement, through all available approaches, health education programmes for adolescents. The intercountry workshop with partners on promoting adolescent health and development using information, education and communication had also

recommended finding creative ways to communicate adolescent health messages and to exercise creativity and responsibility in producing communication tools for the promotion of adolescent development and health. This called for a special focus on the different approaches for health education including peer education, to examine the effectiveness of conveying health messages and changing unhealthy behaviours and to explore the full potential of peer education.

After the adoption of the agenda, the programme was modified to reflect the wish for a continuous working day. The agenda, programme and list of participants are attached as Annexes 1, 2 and 3, respectively.

2. Objectives and methodology

Dr Ghada Hafez, Special Adviser, Gender and Women's Development, WHO/EMRO

Dr Hafez drew attention to the overarching issues and challenges towards the development of strategic directions that have to be set for promoting adolescent health in the Eastern Mediterranean Region, and to the specific area of peer education as a method for health promotion among adolescents. Peer education has become a widespread and popular method to influence adolescent behaviours, which have profound effects not only on the adolescents as individuals, but also on their families and communities.

The workshop was divided into technical presentations, country presentations and group work. Temporary advisers participating in this activity would be asked to suggest areas where the Regional Office's technical support would assist in identifying culturally sensitive, action-oriented approaches to promote adolescent health and development through peer education approach, bearing in mind the existing situation, opportunities and challenges that enable or overcome

operationalizing them in countries of the Region. In addition, all groups would be asked to reflect their inputs in formal presentations and make applications of their recommendations appropriate for country and community interventions. The work of the groups was planned to be presented and discussed at the end of the third day. The last day would be allocated for a plenary discussion that would summarize the input of participating experts in order to reach a consensus on major conclusions and recommendations that underlined of the workshop.

At the end of her presentation, Dr Hafez reminded the participants of the expected results of this activity, which were to:

- have provided technical and policy support to an increased number of countries to improve adolescent health care and to provide them with a safe and supportive environment;

- have developed technical documents to consolidate research and expert opinion about the nature, scope and effectiveness of school health programmes.

3. Technical presentations

3.1 Sex education in promoting adolescent health

Dr M. H. Khayat, Senior Policy Adviser, WHO/EMRO

The concepts of sex education and sexual health are not new, but have become priority issues in recent years due to the increasing exposure of young people to the media and the internet. Sex education is in fact focused on means and norms through which we can convey necessary information about bio-sexual maturation and sexuality to the public in a culturally sensitive manner that respects the age, gender and social environment of the audience population. For example, the child does not regard his or her sex organs with any specific sensitivity, in comparison to other organs. Nonetheless, older people, including the parents, usually interpret the growing interest of children in their sex organs and sexual issues with specific concern, a matter that could be wrongly perceived by children as they do not find a clear justification for such concern. When the parents have adequate knowledge on these issues, they can deal with such situations in scientific and appropriate ways. When a child asks, for instance, why the breast of his mother is different from that of his father, the answer could simply be because the mother needs to breast-feed her infants, but not the father. For more complicated issues, such as those related to pregnancy and childbirth, the necessary information can be provided to the child by giving examples that refer to certain parts of plants, such as flowers and seeds, to answer questions. In this case, flowers are used to refer to sex organs, and seeds to newborn children. In older ages, Islamic teachings indicate that children must be taught how to purify their bodies in preparation for the prayer, and must be given the information required to know why they purify themselves, and in what cases and when they must do this. Several sexual related issues are also

mentioned in the Quran, and should be clarified to children in an appropriate manner. It is recommended to use the plant kingdom to explain such issues for children. Meanwhile, the animal kingdom, and then the human body, can be referred to in case of the older children and adolescents. It is also more appropriate for the mother to provide sex education for her daughters, while the father discusses these issues with his sons.

Sex education, which aims at enabling children and adolescents to avoid sexual hazards and sexual practices outside the marriage institution, and prepare them to behave in a responsible manner to protect their bodies and health, is a religious duty and must be provided to children. The media, particularly the satellite television channels that are very popular among young people, has an important role in dealing with sex education and sexual health issues in a scientific and responsible manner that respects religious teachings.

3.2 Adolescent health and development in the Eastern Mediterranean Region

Dr Ramez Mahaini, Regional Adviser, Women's and Reproductive Health, WHO/EMRO

The dramatic socioeconomic and cultural changes taking place in countries, coupled with the growing size of the adolescent population creates increased challenges to protect and promote adolescent health and development in the Region. Knowledge of the significant rapid changes occurring during adolescence helps young people to understand and adapt to these changes and enables them to avoid becoming victims of many harmful practices and serious illnesses.

The Regional Office has identified six priority components for protection and promotion of adolescent health and development, as follows: good nutrition and dietary habits, healthy lifestyles, mental health, reproductive health and sexuality, personal health and hygiene, and the constitution of

marriage and family. The Regional Office is committed to providing support to countries for introducing technical policies, strategies and plans to reduce risk, morbidity and mortality, and improve psychosocial development of children and adolescents; undertaking research to develop evidence-based integrated interventions for child and adolescent health and development; strengthening capability in countries to devise, test and implement health promotion, prevention and care interventions for children and adolescents in homes and the community; and advocating for policies and strategies to protect the rights of children and adolescents in relation to health and health care.

Since the 1980s, the Regional Office has extended increasing support for building national capabilities in adolescent health and development as an essential component of national health programmes in Member States. In 1996, the 43rd Session of the Regional Committee for the Eastern Mediterranean adopted resolution EM/RC43/R.11, which underlines main strategies recommended for action. In response to the resolution, a set of regional guide manuals on health education for adolescents were developed by the Regional Office in collaboration with IOMS and ISESCO.

For more than a decade the Regional Office and the World Organization of the Scout Movement have maintained a successful collaborative programme aimed at promoting the physical, mental and social well-being of the young people in countries of the Region. The two Regional Offices also collaborated in executing a UNFPA-funded regional project aimed at developing education skills in reproductive health among the scout leaders in several countries.

Technical and financial assistance were provided, in collaboration with the Department of Reproductive Health and Research at the headquarters and through the Pan-Arab Project for Family Health (PAP-FAM), to support national efforts in behavioural research and knowledge, attitudes and practices studies in countries of the Region.

Several challenges are still facing programme support and planning, including: absence of clear national policies and strategies in several Member States; incomplete situational analyses on the health and development status and living conditions of adolescents; insufficiently equipped national health systems to undertake systematic planning; untrained health personnel to provide adolescent-friendly health services; and inadequate financial and technical resources available for adolescent health research.

3.3 Peer education approaches

Dr Abdel Halim Joukhadar, Regional Adviser, Health Education, WHO/EMRO

Adolescence is a gateway to health promotion since key behaviour patterns that influence health and longevity have their origin in adolescence.

Friends and peers represent a major source of information regarding many health related behaviours, particularly reproductive and sexual health issues, and contribute to setting the group norms. Conformity to the peer group is greatest during teenage years. The peer education approach is therefore a very effective way to reach adolescents, provided that peer leaders are carefully selected and trained to communicate health messages and promote healthy behaviours. A peer leader is a volunteer who has leadership potential and is considered by his peers as a natural helper. He is considered as an opinion leader.

A peer leader should be self-confident, open-minded, dependable and honest as well as concerned about the welfare and interests of his peers. A peer leader presents many advantages; young people are likely to imitate or model well liked peers, listen to what respected peers say, and seek support and help from a peer leader both inside and outside the classroom.

Peer leaders should receive adequate training to be able to understand the purpose of the programme, be good listeners,

help the teacher and students in school settings, provide encouragement motivation and support healthy decisions and behaviour. Peer educators should also know other sources of information and counselling so as to refer other peers to appropriate help.

A peer leader trainer should be comfortable with the language of sensitive issues, able to help peer leaders recognize the issue and the different view points expressed in a non-judgmental manner, able to facilitate meaningful and fair discussions and to help learners objectively analyse moral and ethical dilemmas. To this end, a peer leader trainer should meet specific personal qualities and receive adequate training to carry-out his duties.

Cardinal priorities in adolescent health education include: building up a healthy lifestyle; developing interventions within the context of traditions, beliefs, values and behavioural norms; engaging in compassionate and truthful dialogue with adolescents about physical, biological and psychological changes; emphasizing the institution of the family; meeting mental health requirements of a growing adolescent; promoting violence prevention and accident prevention; providing contraceptive education for those entering into a marriage with birth spacing and proper timing of pregnancies as a rule; training parents, teachers, health providers, youth leaders as well as religious leaders; and integrating adolescent health care into the national health system at the primary health care level.

Evaluation studies and best practices point to the following elements of effective preventive programmes: theoretical grounding of interventions; narrow focus on reducing risk-taking behaviours; provision of information on the risks and how to avoid them; instruction on social influences; reinforcement of individual values and group norms against risk-taking behaviour; skills development activities; and adequate training for programme implementers.

Key rules of peer education include: determining target group needs; taking into account sociocultural values as well as the

perceptions and behaviour change stages of target groups; field testing of plans; good elaboration of training materials; good selection of peer leader educators; good training for peer leader trainers, good selection of volunteer peer leaders; providing young people with health-based life skills training; making provision for the turnover of volunteer peer educators; ensuring full respect of the target group's rights and meeting their needs; providing sufficient exposure and training to target groups; systematic documentation of interventions and lessons learnt; close coordination and cooperation with health service providers; establishing and maintaining regular periodic behaviour pattern surveillance systems; and conducting periodic evaluations as well as mid-term and impact evaluations.

3.4 School-based peer health education: challenges and opportunities

Dr Said Arnaout, Regional Adviser, Health of Special Groups, WHO/EMRO

The settings where adolescents live, learn and socialize, including the family, neighbourhood, youth clubs, sports teams, religious settings, scouts, refugee camps, worksites and, in particular, schools, are considered to be unique. Schools have more influence on the lives of young people than any other social institution except the family. They provide settings in which friendship networks develop, socialization occurs, and norms that govern behaviour are developed and reinforced. They also provide access to schoolchildren on a daily basis, facilitating the implementation of many health protection and promotion interventions.

Successful school-based programmes use teaching methods that involve students. Therefore, effective school health programmes include academic skills and knowledge development that make full use of a range of pedagogical techniques, including active learning, peer education, enquiry-based learning, life skills education and staff education through training and development of school personnel. Peer education as a pedagogical working method is applied to the

education of young people, in which the young people themselves are active players and decision-makers in the learning process. It offers education among equals and aims to encourage the active involvement and development of young people through information-sharing, debate and interaction. The pedagogical value and methodology of peer education in school health is gaining increasing attention. Local data and feedback from teachers, students, parents and community members should be collected and used to identify priority areas for improving student health and well-being.

Establishing school-based peer health education programmes and linking them with other relevant programmes is an effective approach to form a comprehensive strategy with health-promoting schools. However, some challenges and concerns regarding the conflict between the philosophy of peer education and traditional programmes should be expected, as well as other related questions, including: how to evaluate the relative contribution of peer-delivered health promotion within a wider health promotion agenda; the sustainability of the introduced programmes; the incentives and motivation systems; and the complexity and cost effectiveness of impact evaluation.

3.5 Effects of peer pressure on eating habits among young people

Dr Khalid A. Madani, Ministry of Health, Saudi Arabia

As children pass through adolescence on their way to becoming adults, they change in many ways. Their physical changes make their nutrient needs high, and their emotional, intellectual, and social changes make meeting those needs a challenge. Along with increased needs for energy and protein, adolescents have higher vitamin and mineral needs compared with people at most other life stages. Five nutrients of particular concern for adolescents are vitamin A, folic acid, zinc, iron and calcium and each of which plays an important role in growth.

Teenagers make many more choices for themselves than they did as children. They are not fed; they eat. They are not sent out to play; they choose to go. At the same time, social pressures thrust choices at them: whether to smoke cigarette or drink alcoholic beverages and whether to develop their bodies to meet extreme ideals of slimness or athletic prowess. During adolescence, peers become a powerful influence over eating habits. Being part of the group can be a problem for a teenager who has a chronic illness or disorder that requires diet modification, such as diabetes, food allergies or phenylketonuria. These adolescents need education regarding diet rationale appropriate to their developmental level and methods of choosing food when in a group of peers.

Understanding the nutrition and physical activity needs of adolescents is important in helping them to develop a healthy body and lifestyle. Two strategies are used for improving nutritional well-being of adolescents. The first is focused one assessment of the nutritional status of adolescents, while the second stresses the need for creating an environment that enables accepting change in eating habits.

Nutritional assessments should include an evaluation of the nutrition environment including parental, peer, school, cultural and personal lifestyle factors. The attitude of the adolescent towards food and nutrition is also a primary component of a comprehensive evaluation. A prime component of nutritional counselling for adolescents is helping them overcome perceived barriers to eating well.

Because of their increasing independence, any attempt to help adolescents improve their nutritional status requires careful planning. For a plan to succeed, the adolescent must be willing to change; therefore, an assessment of teenager's desire to change is essential.

Adolescence is a period of tremendous physical and cognitive changes. It is considered a nutritionally vulnerable period because of the increased needs of all nutritionists and the changes in lifestyle and food habits that affect nutrition intake. Therefore, during adolescence, peers become a powerful

influence over their eating habits. The credibility of parents is often questioned in the face of advice from teachers, peers or peers' parents. Positive behaviours, such as a willingness to try new foods, need to be reinforced.

3.6 Global school-based health surveillance system

Dr Abdel Halim Joukhadar, Regional Adviser, Health Education, WHO/EMRO

The Global School-based Health Surveillance System (GSH) has been developed by the Centers for Disease Control and Prevention, Atlanta, in collaboration with WHO. It represents a contribution within the school setting to the WHO Stepwise approach to noncommunicable disease surveillance. The GSH includes multiple complementary components such as the Global School-based Student Health Survey (GSHS), the School Personnel Survey and other related surveys. The purpose of GSHS is to: provide accurate data on students to help countries develop priorities, establish programmes and advocate for resources, and to allow international agencies and countries to make comparisons across countries and establish trends in the prevalence of health behaviours and protective factors by country. The Survey instrument consists of three questionnaires: the core questionnaire modules, the core-expanded questions, and country-specific questions. The ten modules of the core questionnaire cover the following: respondent demographics; alcohol and other drug use; dietary behaviours; hygiene; mental health; physical activity; protective factors; sexual behaviours that contribute to HIV infection, other sexually transmitted diseases and unintended pregnancy; and violence and unintentional injury. At least 6 of the 10 core modules must be used to be part of the GSHS. Once a core module is selected, all questions must be used without modification. It is to be noted that all questions share common characteristics: multiple choice with mutually exclusive alternatives.

A GSHS capacity building plan includes the following steps: survey implementation workshop to train national coordinators on issues relating to sampling, survey

administration and questionnaire design. The conduct of the survey in a country follows a training workshop to enable countries use *EpiInfo* software for statistical analysis, analyse the collected data and write the survey report. Once the national report is ready, a data application and programme planning workshop is conducted to enable national authorities to elaborate policies and programmes and plan interventions on the basis of the survey findings. Programmes and interventions are implemented accordingly and after 2 years a repeat GSHS is conducted. This constitutes a surveillance system. WHO and CDC provide survey implementation workshop, CDC assists national coordinators with sample design and selection as well as in questionnaire design. CDC also provides the survey implementation handbook and answer sheets (and scans them) and performs data cleaning and weighting, in addition to providing ongoing capacity building and technical support. Both WHO and CDC facilitate, as appropriate, funding of the Survey. In addition, CDC provides initial reports and electronic data file, fact sheet on key findings, assists with preparation of country reports and assists with data dissemination strategies.

The GSHS has been implemented in six African countries, and a data analysis and reporting workshop is planned for February 2005. The GSHS has been implemented in the Western Pacific Region (3 provinces in China and the Philippines). In the Region of the Americas, 3 countries have implemented the survey out of 10 countries trained to implement the survey. Two survey implementation workshops were conducted in the Regional Office for the Eastern Mediterranean in September and October 2004, respectively. Eleven countries participated. Jordan implemented its survey in early 2004.

4. Country presentations

4.1 Bahrain

The adolescent peer education approach has been adopted in several areas of health promotion programmes in Bahrain, including: health promoting schools, prevention of hereditary blood diseases, prevention and control of sexual transmitted diseases, promotion of healthy lifestyles, promotion of mental health and environmental health. Efforts are being concentrated at the current stage to formulate a holistic national strategy that involve all concerned partners in adolescent peer education in the country

4.2 Egypt

Egypt is faced with a high population growth rate and imbalance in geographical distribution of population. This maldistribution of population has resulted in economic constraints and is influencing the stability and progress of the Egyptian society and affecting the quality of life of the people. Key strategies to address this issue encompass a variety of aspects of the human life including reproductive health and family planning, child health, increase in the literacy rate, care for the adolescents and youth, empowerment of women, population redistribution, protection of environment and support for research activities. The adolescent and youth care strategy addresses the major challenges, including the shift of the population composition towards younger age groups, high rates of early marriages, unplanned pregnancies and sexual abuse of young people. The goal is empowering young people for making informed decisions and choices for promoting their own health and well-being through different

approaches including adolescent peer education. Adolescent peer education is being implemented in the country through three phases. The first is focused on training of trainers at the governorate level, including: the governorate family planning director; information education and communication officer; the squatter areas officer and the population educator. In the second phase, the trained trainers at the governorate level train their counterparts at the district level. The last phase entails formulating appropriate plans of action to be implemented in the local communities of the trained district officers.

4.3 Jordan

The planned five-year strategies for adolescent school health in Jordan are mainly focused on preventive rather than curative aspects of adolescent heath, as this approach is believed to be more cost-effective. These strategies include: 1) incorporating sexual and reproductive health programmes into health-promoting schools and expanding peer education activities; 2) initiating psychosocial counselling services in the school; and 3) updating the health curricula of the Ministry of Education, with specific focus on substance abuse; oral health; healthy nutrition; prevention of HIV/AIDS and other sexually transmitted infections and prevention of accidents caused by risky behaviour.

4.4 Lebanon

The private sector is the main player in the delivery of services in Lebanon. The number of registered nongovernmental organizations in Lebanon is 4073. Statistical estimates show that 39% of the Lebanese school students are registered in public schools while 61% are in private ones. Most national programmes and strategies designated for adolescent peer education in Lebanon are directed towards HIV/AIDS prevention. Progress towards formulating a holistic approach

to adolescent peer education has been slow; however, some nongovernmental organizations have taken on this concept and are frontrunners in peer education. The implementation of appropriate peer education programmes has proved to be more expensive than planned, and more financial resources are needed.

4.5 Morocco

Morocco has set up a youth-to-youth pilot project for three years (2004–2006). The project is aimed at responding to the psychological and development needs of youth in the country. The project activities are being implemented by three governmental sectors, namely: ministries of health, education and youth. The project administration has set up a well-formulated plan to ensure close coordination with the concerned local nongovernmental organizations at the central, regional and community levels.

4.6 Oman

In collaboration with WHO, Oman started in 2000 to put adolescent health and development under sharper focus. National qualitative and quantitative studies were undertaken in the country, and the findings of these studies were shared with all interested parties and through all available channels, including a national dissemination symposium, which was held in 2002 and attended by senior officials of the country. As a result, a national advocacy strategy for adolescent health and development was formulated in 2003, with specific focus on reproductive health issues and healthy lifestyles. The strategy was officially adopted by the governmental and nongovernmental institutions, which are expected to implement this strategy in the coming five-year national plan of action. Moreover, an adolescent peer education project started in 2003 to address the issue of HIV/AIDS through school students in Muscat.

4.7 Saudi Arabia

The adolescent population in Saudi Arabia is around 4.5 million according the 2004 census. Although there might be trials in peer health education in the country, no data are available to describe these trials, who is doing them or where they are being conducted.

The School Health Department in the Ministry of Education has taken responsibility for developing a programme for peer health education among adolescents that will be implemented through school health services in the country.

The objective of the peer education programme is to develop strategies and plans, which are expected to upgrade adolescents' knowledge and skills about their health and enable them to transfer it to their peers using the available resources. These strategies also aimed at providing adolescent peer educators with peer leader's skills. A plan of action has been developed, including appropriate steps for evaluating this programme.

4.8 Tunisia

The peer education experience in Tunisia goes back more than 40 years, when it was adopted in the family planning programme. The adolescent peer education approach was initiated through the health club initiative in the country in 1990. This approach is considered to be an integral component of every adolescent health education programme, as different studies have shown that the most common source of information among young people is their peers. Selection of peer educators is considered to be a crucial step, as these educators must demonstrate good models of knowledge, attitudes and practices to their peers and be able to gain their trust.

4.9 Yemen

Scouting incorporates a remarkable educational method which is carried across the different scout stages. The important role of peers throughout these stages is well illustrated by the scout movement in Yemen. The youth-to-youth project is considered to be an excellent model of peer education in the country. As a result, the Yemeni Scout Association, in collaboration with the Ministry of Youth, civil social institutions and UNFPA and WHO, formulated a national strategy for youth and development. The strategy has become one of the most important references for development plans in the country, as it directly confronts problems of youth and outlines appropriate actions accordingly.

5. Group work

The group work was divided into three separate sessions, which would culminate in highlighting strategies for using adolescent peer education for promoting adolescent health and development in the Region. The groups had three tasks.

- Discussing and outlining prerequisites for successful peer education approaches in formal and non-formal settings.
- Identifying emerging priorities and issues in peer education in countries of the Eastern Mediterranean Region.
- Elaborating the required guidelines to promote adolescent peer education activities in the field of formative research, capacity building, follow-up and evaluation.

The groups used guiding principles to accomplish these tasks, including underlining: the role of studies and research in identifying priority areas for adolescent peer education; the need for strengthening and upgrading advocacy activities for

strengthening the commitment of the concerned decision makers; the technical areas whereby the national capacity needs to be enhanced; the significance of active involvement and participation of the young people in their own peer education activities; and the effects of stressing partnership among all concerned sectors and agencies in relation to programme implementation and sustainability. The groups identified various critical issues to be considered in devising strategies for adolescent peer education interventions. Focus was placed on creating opportunities for building capacities among the concerned service providers, as well as among political, religious and community leaders. Integration of adolescent peer education in the relevant existing programmes was considered to be a key strategy that countries and concerned organizations should employ. However, certain measures were emphasized in order to ensure appropriate distribution of the designated tasks of these interventions, appropriate training of the involved personnel, and active supervision, monitoring, evaluation and reorientation of the implemented programme activities. Promoting networking with identified stakeholders and target groups was considered to have a significant role in achieving expected programme results in the community.

School health was considered as an appropriate entry point for adolescent peer education interventions. In view of the increasing role of media and its impact on everyday life, special attention should be given to developing skills for deconstructing commercial media messages and understanding the underlying ideologies used to promote risky behaviours such as smoking, alcoholism and violence.

6. Conclusions

- Adolescent health is not receiving the appropriate attention in some countries of the Region, as adolescents are considered neither adults nor children. There is a need to acknowledge that adolescents have special needs that should be addressed appropriately, bearing in mind the multisectoral nature of adolescent health.

- In certain settings, adolescent health has been given low priority as a result of scarce resources and competing priorities.

- Peers are a main source of information to adolescents, as has been demonstrated by research.

- Schools could be the ideal setting for promoting the health of in-school adolescents, especially where school enrolment is high. Nonetheless, in some countries, out-of-school adolescents constitute a significant proportion of this age group and should not be neglected.

- The formal education sector has a very important role in developing the required knowledge and skills for promoting peer education activities.

- Adolescent health in general and peer education in particular should not be delivered through vertical programmes, but rather through existing services such as primary health care and school health services. This approach will minimize stigma in seeking care and is cost-effective as it utilizes already existing resources.

- Peer education is considered to be one of the effective tools for promoting healthy behaviours among young people. The

role of parents, families and schools in the provision of information should be emphasized. Children need different levels of information and skills throughout their life-cycle, and parents, families and schools should provide it for them.

- Particular attention should be paid to adolescents with special needs, especially in emergency situations.

- Peer education is not a simple and easy approach. It needs appropriate pre-implementation preparations, training, careful selection of peer educators, replenishment of peer educators due to turnover, supervision, evaluation with selection of relevant indicators, as well as a system for assessment, monitoring, feedback, support and corrective actions in place.

- Allocating the required financial and technical resources in order to adapt appropriate national adolescent peer education programmes is considered to be a priority for promoting adolescent health and development in the Region.

7. Recommendations

Member States

1. Develop a clear peer education programme integrated within the existing adolescent and school health programmes, including action-oriented school health curricula. Special attention should also be paid to out-of-school adolescents.

2. Ensure political commitment for the promotion of adolescent health and development, particularly through peer education.

3. Establish baseline data and situation analyses on adolescents' knowledge, attitudes and behavioural patterns in order to set up country-specific profiles, identify priorities and monitor progress. In order to emphasize the use of data generated from research and studies in adolescent health and development programmes, including peer education, countries need to ensure that the selected survey questions are in line with local sociocultural values and standards.

4. Establish appropriate mechanisms to ensure close coordination and cooperation between the different concerned parties, with specific focus on parents, families and schools. Necessary plans should be formulated in order to ensure active partnership among all concerned parties, including: Ministries of Heath, Education, Youth, Information, Media, Social Affairs, Interior, as well as the Scouts and other international and nongovernmental organizations.

5. Ensure active participation of adolescents in the planning, implementation, monitoring and evaluation of the peer education programme.

6. Develop and adapt necessary technical guidelines and tools in order to strengthen adolescent peer education programmes and activities in countries of the Region.

7. Secure necessary financial and technical resources in order to implement appropriate national adolescent peer education programmes and ensure their sustainability.

WHO/EMRO and other concerned organizations

8. Advocate the peer education approach as an effective tool for promoting adolescent health in the Eastern Mediterranean Region.

9. Develop appropriate and culturally-sensitive technical guidelines and tools to support adolescent peer education activities. The multi-media action-oriented school health curricula can serve as a model.

10. Support and strengthen research and networking on peer education in the Region, within the context of the prevailing social and cultural values.

Annex 1

Agenda

1. Inaugural session
2. Welcome and opening remarks
3. Introduction of participants, election of Chairperson and Rapporteur
4. Adoption of the Agenda
5. Objectives, mechanics and expected outcomes of the workshop
6. Sexuality education within the cultural context of the Region
7. Adolescent health and development in the Eastern Mediterranean Region
8. Peer education approaches
9. School-based peer health education: challenges and opportunities
10. Effects of peer pressure on eating habits among young people
11. Global school-based health surveillance system
12. Country presentations of existing national programmes, strategies and approaches designated to adolescent peer education in formal and non-formal settings: Bahrain, Egypt, Jordan, Lebanon, Morocco, Oman, Saudi Arabia, Tunisia and Yemen

13. Working sessions in three groups to:

- Discuss and outline prerequisite of successful peer education approaches in formal and non-formal settings
- Identify emerging priorities and issues in peer education in countries of the Eastern Mediterranean Region
- Elaborate the required guidelines to promote adolescent peer education activities in the field of formative research, capacity building, follow-up and evaluation

14. Group presentations and plenary discussion

15. Major conclusions and recommendations

16. Closing session

Annex 2

Programme

Monday, 6 December 2004

8:30–9:00	Registration
9:00–10:30	Inaugural session
10:30–11:00	Introduction of participants Election of Chairperson and Rapporteurs Adoption of the agenda
11:00–11:30	Objectives, mechanics and expected outcomes of the workshop, Dr Ghada Hafez
11:30–14:00	Sexuality education within the cultural context of the Region, Dr M. Haytham Khayat
14:00–14:30	Adolescent health and development in the Eastern Mediterranean Region, Dr Ramez Mahaini
14:30–16:00	Peer education approaches, Dr Abdel Halim Joukhadar
16:00–16:30	School-based peer health education: challenges and opportunities, Dr Said Arnaout
16:00–16:30	Effects of peer pressure on eating habits among young people, Dr Khaled Madani
16:30–17:30	Plenary discussion

Tuesday, 7 December 2004

9:00–10:00	Global school-based health surveillance system, Dr Abdel Halim Joukhadar
10:00–10:30	Plenary discussion

10:30–12:15	Country presentations of existing national programmes, strategies and approaches designed to adolescent peer education
12:15–14:00	Briefing for group work sessions
14:00–17:30	Work sessions in three groups to:
	A: Discuss and outline pre-requisite of successful peer education approaches in formal and non-formal settings; **B:** Identify emerging priorities and issues in peer education in countries of the Eastern Mediterranean Region; and **C:** Elaborate the required guidelines to promote adolescent peer education activities in the field of formative research, capacity building, follow-up and evaluation.

Wednesday, 8 December 2004

9:00–14:00	Group work (continued)
14:00–16:00	Group presentations
16:00–17:00	Plenary discussion

Thursday, 9 December 2004

9:00–11:00	Plenary discussion
11:00–12:00	Plenary session: major conclusions and recommendations

Annex 3

List of Temporary Advisers

BAHRAIN
Dr Ali Al Baqara
Chairperson
Adolescent Health Committee
Ministry of Health
Manama

Dr Mariam Al-Mulla Harmas
Chairperson
School Health Services
Ministry of Health
Manama

Dr Bahya Abdulla Suwelh
Specialist
Family Education Section
Ministry of Health
Manama

EGYPT
Dr Yahia El-Hadidi
Undersecretary
Reproductive Health and Population
Ministry of Health and Population
Cairo

JORDAN
Dr Haidar Mustafa Al-Atoum
Director of School Health
Ministry of Health
Amman

IRAQ
Dr Majeda Ahmed
School Health Programme Manager
Ministry of Health
Baghdad

LEBANON
Dr Reem Rabah
Makased Charity Association
Beirut

MOROCCO
Dr Abdel Ghani Maroufi
Partnership Head Service
Ministry of National Education
Rabat

OMAN
Dr Yasmin Ahmed Jaffer
Director
Family and Community Health
Ministry of Health
Muscat

SAUDI ARABIA
Dr Sulieman Al-Shehri
Director General
School Health Services – Girls Education
Ministry of Education
Riyadh

Dr Khalid A. Madani
General Supervisor
Nutrition Department, Mecca Region
Vice President of Saudi Society for Food and Nutrition
Ministry of Health
Jeddah

TUNISIA

Dr Alya Mahjoub Zarrouk
Director
School and University Health Services
Ministry of Public Health
Tunis

Dr Aida Ismail
Vice Director
School and University Health Services
Ministry of public Health
Tunis

Dr Mohamed Mokdad
School Health Department
Ministry of Public Health
Tunis

Dr Wahiba Maatouk
Coordinator
School Health Department
Ministry of Public Health
Monastir

YEMEN

Mr Abdellah Obaid
General Commissioner of Scout Movement
Sana'a

OTHER ORGANIZATIONS

United Nations Children's Fund (UNICEF)
Dr Akthem Fourati
UNAIDS Focal point
Tunis

United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA)
Dr Haifa Madi
Deputy Director of Health
Chief Health Protection and Promotion
Amman

International Planned Parenthood Federation (IPPF)
Dr Magdy Khaled
Director
Programme Support and Development
Tunis

Mrs Chafia Boulfoul
IPPF
Algeria

Dr Zohra Turki
IPPF
Tunis

Ms Lina Chichakli
Consultant
Cairo

International Federation of Medical Students' Associations (IFMSA)
Dr Hesham Hamouda
Project Director
Kuwait

Dr Fatma Odaymat
Regional Coordinator for the Eastern Mediterranean
Beirut

WHO Secretariat

Dr Ghada Hafez, Special Adviser, Adolescent Health, WHO Regional Office for the Eastern Mediterranean

Dr Ibrahim Abdel Rahim, WHO Representative, Tunisia

Dr Abdul-Halim Joukhadar, Regional Adviser, Health Education, WHO Regional Office for the Eastern Mediterranean

Dr Said Arnaout, Regional Adviser, Health of Special Groups, WHO Regional Office for the Eastern Mediterranean

Ms Fatma Abdel Megeed, Help Desk Assistant, WHO Regional Office for the Eastern Mediterranean

Ms Baheya El Sherif, Administrative Assistant, WHO Regional Office for the Eastern Mediterranean

Mrs Maha Wanis, Secretary, WHO Regional Office for the Eastern Mediterranean