Making Policy Happen

Lessons from countries on developing national adolescent health and development policy

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List of Abbreviations

ADH	Adolescent health and development
ASRH	Adolescent sexual and reproductive health
ARH	Adolescent reproductive health
EU	European Union
CRC	International Convention on the Rights of the Child
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome
ICPD	International Conference on Population and Development
IMF	International Monetary Fund
ILO	International Labour Organization
MDG	Millennium Development Goals
MOH	Ministry of Health
MOY	Ministry of Youth
NGO	Non-Governmental Organization
NYP	National Youth Policy
PAHO	Pan American Health Organization/WHO
WPRO	Western Pacific Regional Office of the WHO
EMRO	Eastern Mediterranean Regional Office of the WHO
EURO	European Regional Office of the WHO
SEE	South-Eastern Europe
SEARO	South-east Asia Regional Office of the WHO
AFRO	African Regional Office of the WHO
UN	United Nations
UNAIDS	United Nations Global Program on HIV/AIDS
UNICEF	United Nations Children's Fund
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
SIECUS	Sexuality Information and Education Council of the United States
STI	Sexually Transmitted Infection
SSOC	United Nations Special Session on Children
WHO	World Health Organization
WHA	World Health Assembly

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Introduction

WHO Member countries are increasingly interesting in developing national policy for adolescent health and development. From a historical perspective, the World Health Assembly (WHA) since 1989 has been urging countries to adopt a "declared health policy which clearly spells out the government's attitudes and responsibilities to youth and health-related matters that pertain to young people…" and that "countries should review legal structures, instruments, legislation, and law enforcement mechanisms that affect the well-being of youth and take steps to improve and strengthen them in order to enhance the conditions and circumstances necessary for the healthy development and living of young people"(WHO, 1996). WHO Regional offices have followed suit by holding a meeting with member countries to approve strategies and plans of actions for adolescent health and development which call for the development of national policy for Adolescent Health and Development (ADH). As such, many countries in each of the Regions have developed policies specific to adolescent health and most have worked towards a supportive policy environment towards adolescent health and development.

The existence of national policy is not a guarantee for high quality programmes or outcomes for adolescent health and development, however, those countries with strong adolescent health and development programs tend to have a supportive political environment as well as policies and legislation related to ADH. In addition, countries with National Adolescent Health and Development (ADH) Policy have attested to the fact that the existence of explicit policy provides vision, co-ordination, strategy and sustainability for improved programming. The areas of HIV prevention and tobacco control and prevention are examples of how a favourable political environment and subsequent policies and legislation have contributed towards improved health situations.

Most countries are signatory to the UN Convention on the Rights of the Child, whereby the "child" is defined up until 18 years of age, which includes the adolescent years. Additionally, countries have participated in international consensus-building meetings such as the UN Special Session on Children (SSOC), the UN International Conference on Population and Development (ICPD), and the Millennium Development Goals (MDG). This international political environment provides a framework for the development of comprehensive policies, plans and programs for adolescent health and development.

Given the recent interest of WHO member countries in developing national policy for adolescents, WHO has developed this document to support countries in develop policy to further programming for ADH. The document is designed for national program managers and policy makers to guide the policy formulation process on adolescent health and development. It will be particularly useful for countries considering the formulation of new policies or making changes to existing policy and legislation. The document will also provide guidance to regional level program managers in their support to countries in the policy development process, as it provides evidence of how policy can serve to improve programming for adolescent health and development.

This document is based on several policy assessments conducted by WHO countries as well as information gathered in various publications. Therefore, it integrates the experiences and lessons of several countries around the world in developing policy and legislation. The various country experiences indicate similarities among countries, but at the same time caution that there is no key formula or recipe for policy development. The details, sequence and approaches vary from country to country and depend on various factors, including the policy environment, resources available and political commitment for adolescent health and development. Therefore, this document will

focus on the main steps and lessons presented as important to the ADH policy development process.

This document is organized into the following three sections:

- The first section sets the scene for policy development by providing operational definitions of adolescent health and development, policy and legislation in its various forms, and why national policy is important to programming.
- The second section presents the key steps in developing national policy, which includes steps on assessing the political environment and the situation of adolescents. This section also provides guidelines on deciding which policy options to take and goes into detail on the policy formulation process.
- The last section deals with the practical issues countries face in relation to policy development and implementation.

Part I. Background

1. WHAT DOES WHO MEAN BY ADOLESCENT HEALTH AND DEVELOPMENT?

In the past decade, our knowledge of what constitutes adolescent health and how it is connected to adolescent's development has expanded rapidly. It is well documented that the period of adolescence (10 to 19 years)[1] is one of rapid growth and development in which adolescents develop the necessary competencies and skills to adopt adult roles in society. It is a time for building social, personal and livelihood skills, establishing a sense of identity, developing sexuality identity, forming ties to the larger society and developing social values.

Adolescents make up approximately 20% of the world's population, 85% of which live in developing countries, increasingly in urban settings. Globally, 45% of adolescents are out of school.

Adolescents are generally thought to be healthy, as mortality in adolescence is lower than in any other age group. Indeed most adolescents are growing up healthy, however the period of adolescence is also a period in which health and development-compromising behaviours, such as disconnecting from school, dietary and physical activity patterns, initiating use of substances such as tobacco and alcohol, unsafe sexual practices and engaging in violence, are learned. These behaviours cause morbidity and mortality in adulthood but their roots can be traced back to the adolescent period. Tobacco use, for example, typically starts before the age of 20 and frequently leads to premature death later in life. HIV infection, which is often contracted in adolescence, leads to AIDS in later years. The major cause of death in young people are to road traffic accidents, injuries, suicide, violence, pregnancy related complications, HIV/AIDS and other illnesses such as malaria that are either preventable or treatable.

The ***developmental approach*** to adolescent health, that WHO promotes, is based on the evidence that health problems are intimately linked to the physical and psychosocial development over the adolescent period. Some health risks emanate from developmental tasks such as learning to cope with adult behaviours related to substance use and sexuality. Evidence indicates that behaviours underlying mortality and morbidity are interrelated and have common roots. Unprotected sex, for example, increases the risk of both unwanted pregnancy and infection with STIs (including HIV/AIDS). Intravenous drug use can also spread HIV and alcohol and other drug abuse can lead to increased accidents and violence including homicides. There are clusters of risk and protective factors at the individual, familial and environment level that underlie adolescent behaviour and health outcomes. For example, at the individual level, having self-efficacy and an internal locus of control can contribute to an adolescent's resilience. At the family level, adolescents that have a supportive and positive relationship with parents and parents that encourage self-expression are less likely to experience depression, initiate sexual intercourse early and use substances such as alcohol and/or drugs. At the social/environmental level, being connected to community and schools as well as a supportive policy environment can also protect young people. Attention to the underlying causes of a specific problem can help to support multiple issues that face adolescents, a concept that can be used to guide policy and programming.

[1] WHO refers to people aged 10-19 as adolescents. The term 'young people' refers to those between 10 to 24 years old. The UN definition of youth are those aged 15-24.

In response to this evidence, WHO and its partners, UNFPA and UNICEF share a common agenda framework that provides a comprehensive approach to health and development. As young people's health problems have common roots, WHO, UNFPA and UNICEF have joined expertise to address the issues most effectively through a combination of mutually supportive interventions to promote healthy development. The Common Agenda outlines the following actions needed to provide adolescents with the support and the opportunities to:

- Acquire accurate information about their health needs
- Build the life skills needed to avoid risk behaviours
- Obtain counselling, especially during crisis situations
- Have access to health services
- Live in a safe and supportive environment.

A political and legislative environment favourable to adolescent health and development constitutes one of the layers of the "safe and supportive environment" in which adolescents live. It is therefore an integral part of achieving the goals of the Common Agenda: the healthy development of adolescents and the prevention of ill health. Policies are also pivotal in the implementation of the other intervention areas. As many WHO member countries have adopted the adolescent health and development approach, and are working towards the goals set out in the Common Agenda, the development of ADH policy, including legislation is a key function of government, in which WHO can provide technical assistance.

Key Resources:

1. WHO. The Second Decade: Improving Adolescent Health and Development. Department of Child and Adolescent Health and Development. 2001.
2. WHO. Broadening the Horizon: Balancing protection and risk for adolescents. Department of Child and Adolescent Health and Development. 2002.
3. WHO/UNFPA/UNICEF. Action for Adolescent Health: Towards a common agenda. Recommendations from a joint study group. Adolescent Health and Development Programme. 1997

2. FUNDAMENTAL CONCEPTS: WHAT DO WE MEAN BY POLICY?

The term policy is used in different ways and at various levels. The Oxford Dictionary (1991) defines a policy as a course or principle of action adopted or proposed by a government, party, business or individual. WHO defines policy as a written "expression of goals for improving the health situation, the priorities among these goals, and the main directions for attaining them (WHO, 1986, as cited in PAHO, 1999, Rodriguez-Garcia, Russell)

The definitions cited above were drawn upon to create the following working definition of policy, as it relates to adolescents, for the purposes of this paper: ***a statement or expression of goals or principle of actions to improve the health and development of adolescents (aged 10 to 19 years).*** Policy can occur at the international, regional and national level, through consensus building of a several governments, or at the national level. The working definition deviates from the WHO definition, as some examples of adolescent policy do not include "the main directions for

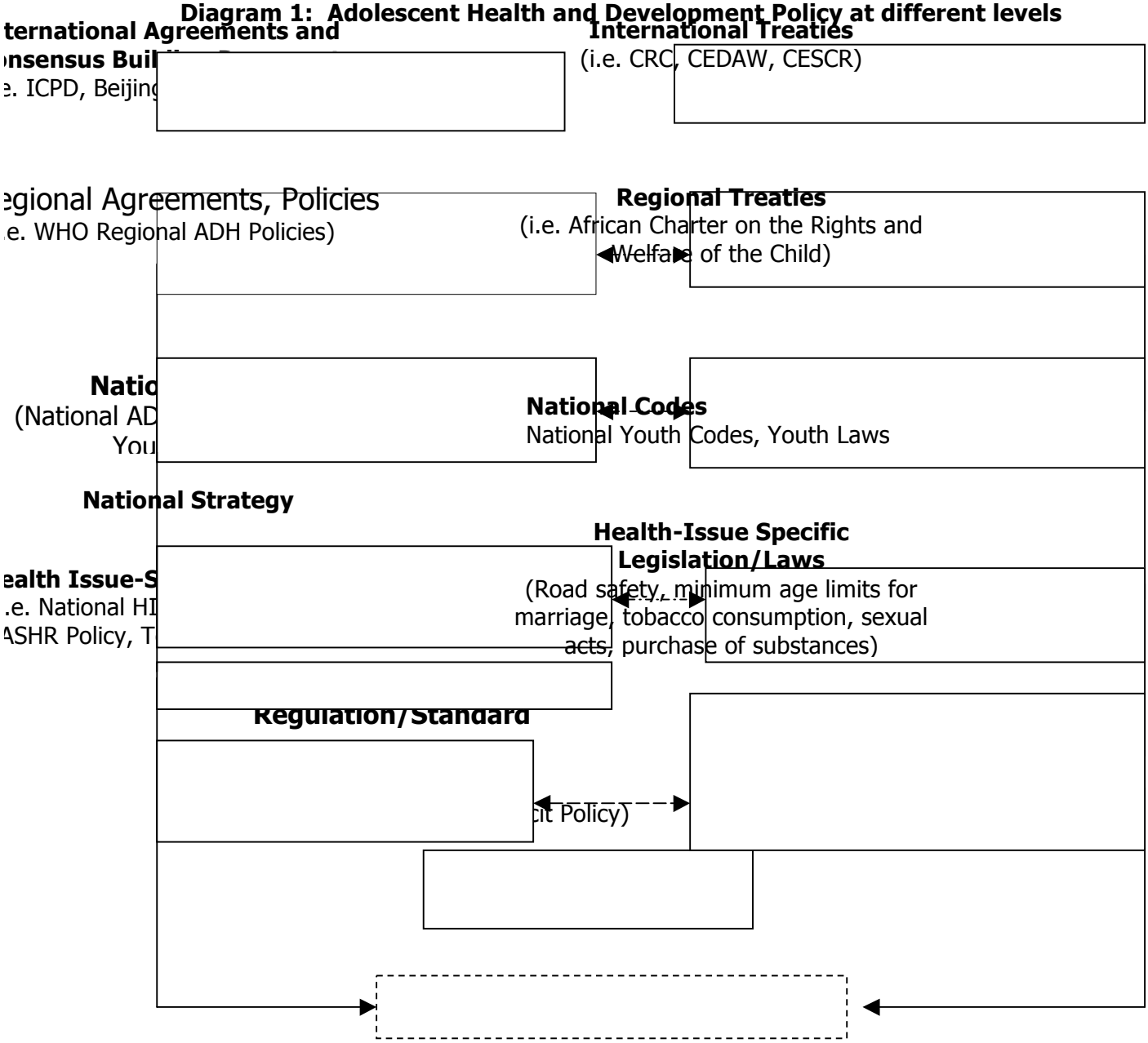
attaining goals". Some countries rather refer to this as strategy. More specific definitions of each of the terms follow the ***Diagram 1***.

When discussing policy, the topic of legislation is invariably linked to policy, or vice versa. ***Diagram 1*** below distinguishes the various forms of policy and legislation that exist with reference to adolescent health and development, based on country assessments, documents and discussions with professionals working in the area. Examples of how each play out at the country level with respect to adolescent health and development will follow in a later section.

The left side of the diagram represents policy – non legally binding documents or statements of intention, while the right side represents various forms of legislation— legally binding instruments. Regulations fall in between both. The diagram makes two assumptions: one is that the aim of any type of policy is for it to be approved by the government. In a few countries, Policy has been ratified to become part of the legislative framework. The other assumption is that policy and legislation are formulated with the goal of improving adolescent programming through better co-ordination and improved sustainability of national adolescent programs at the national level.

Forms of Policy **Forms of Legislation**

Diagram 1: Adolescent Health and Development Policy at different levels



Forms of Policy:

International Consensus building documents refer to United Nations Declarations and Platforms of Action (such as the International Conference on Population and Development (ICPD) and the Beijing Platform of Action and the Special Session on Children (SSOC)). These consensus building conferences generate internationally agreed upon declarations and platforms of action which are examples of policy at the international level. Contrary to Treaties or Conventions, these declarations are non-binding, although many norms and standards enshrined therein reflect principles which are binding in customary international law (WHO, 2002, 25 Questions and Answers on Health and HR)

As mentioned above, the term ***National Policy*** refers to a statement or expression of goals or intentions adopted by a government for implementation at the national level. They are not legally binding and tend to be multisectoral in nature. Examples of national

policy are indeed, a National Health Policy (comprehensive and includes various sub-sectors within health, such as nutrition, maternal and child health, reproductive health, etc.).

Regional Policy in the form of Regional Plans of Action, Strategies. WHO/SEARO in 1996, conducted a regional meeting for development of a regional strategy for adolescent health and development, in which all countries in the region constructed objectives, approaches and goals for adolescents in South East Asia. The strategy called for the formation of national strategies. WHO/PAHO in 1989 developed a regional plan of action with all 46 member states of the Americas to develop a joint plan of action which outlines the line of action for countries to address adolescent and youth health and development. That plan of action also called for the development of national policies for adolescents and youth. During the WHO African Regional committee, in August 2001, the regional Adolescent Health Strategy was presented to Member States for adoption and implementation in the Africa Region.

A ***National Strategy*** addresses the "how" of a national policy by defining actions to achieve policy goals and objectives. It differs from national policy in that it is operational in nature. It differs from an implementation plan, plan of action, work plan or operational plan, as they map out actual activities at regional, district/department, or municipal levels, roles and responsibilities, timelines and budgets for implementing the policy (see section 4.1 on making the policy operational). In some countries, national policy is actually formulated to resemble national strategy in that it includes "how to" accomplish its goals.

Countries, such as Nepal and Tanzania, developed National Strategy, in lieu of a national policy or to supplement the national policy. The reasons some countries choose to develop a strategy is linked to the existing policy environment and the political and legal framework in which a policy or strategy can be adopted at the national level.

There are ***health issue-specific policies*** as well. These can be distinguished from national policy as they are usually based on a specific health issue, within the health sector, and often times, address a health problem. For example, there may exist a policy on HIV, maternal health, tobacco, substance use, or reproductive health. For the purposes of this document, references to health issue specific policy are those that focus on a specific health issue, and span the life cycle, rather than focus a particular age group (such as the child, adolescent, adult or elderly) and the various health issues that concern that population.

Finally, policies can be implicit. ***Implicit policy*** is derived from the nature of ongoing programmes in the areas of health or adolescence. (WHO 1991 document). Some countries do not have explicit national policy (policy that is specifically delineated in an official statement or document) but it exists implicitly through programming and services at the national level. Implicit policies through programming can be evidenced through existing norms, regulations and standards used in clinical and programmatic settings.

Forms of Legislation:

International Agreements or Treaties. Treaties are international agreements that create legally binding obligations. Covenants, protocols, conventions and charters are all kinds of treaty. Treaties are referred to as instruments when they are used as tools of international law.

International human rights treaties are binding on governments that ratify them. The World Health Organization is in the process of drafting its first international treaty for

tobacco prevention, The Framework Convention on Tobacco Control and hopes that by next year, this Convention will be ratified by member states[2].

A ***Code*** is defined as a systematic collection or digest of laws of a country, or of those relating to a particular subject (Oxford). Countries in Central and Latin America such as Nicaragua, Costa Rica, and Bolivia have developed **Youth Codes** (Codigo de Juventud), that are rights based and serve to ensure youth as social agents in civil society. They tend to be multisectoral and have a broad youth development mandate (which includes health) and establishes by decree a youth institution, in the form of a Ministry or Vice-Ministry of Youth. Once a Youth Ministry (or Vice Ministry) is created, the responsibility for establishing national policies and legislation related to young people would fall under the legal jurisdiction of that ministry.

Legislation is defined as the laws or regulations enacted by a national law making body and is therefore legally binding. Legislation is created to offer protection, often driven by a particular issue or problem. For example, there could be legislation regarding road safety, the minimum age at marriage, or on the use of tobacco or alcohol consumption. Legislation is often sets age parameters for consent and is formulated to protect minors, prohibit certain acts against minor or by minors, and/or grants certain rights and responsibilities.

Regulations and standards are defined as a rule prescribed for the management of some matter, or for the regulating of conduct; a governing precept or direction; a standing rule (Oxford Dictionary). They fall in between policy and legislation in that they are not necessarily legally binding within a State's legal system, but can be binding within a certain jurisdiction. For example, institutions, such as Ministries, clinics and hospitals and professional agencies (medical associations, etc) have regulations, which are not binding within the State, but can have punitive repercussions for members of a given institution. For the purposes of adolescent health and development, an example would be regulations with respect to services for adolescents where service providers have certain regulations (or standards) by which they must abide.

Example: Standard: Mongolia - Taiwan (can we use)

[2] For a list of documents related to the Framework Convention on Tobacco Control, see http://www.who.int/gb/fctc/

Age: A Defining Factor for Policy and Legislation

Adolescents are defined by WHO as persons between the ages of 10 and 19, youth as those between 15 and 24 years. The term 'young people' is referred to those between the ages of 10 and 24 years. This document addresses policies for adolescents as defined by the age group 10 to 19 years, recognizing that some countries define the period of adolescence differently.

Age is particularly important to consider when looking at policies and legislation related to adolescents and youth. Although WHO has standardised its definition of adolescence and youth, the actual interpretation of adolescence and youth remains a social construct that varies between cultures. What characterises the period of adolescence (10-19 years of age) are the physical, cognitive and psychological growth and development that occurs—although the prescribed age for the stages of growth is not strictly defined. Cultural rites of passage, such as marriage and childbearing distinguish young people from adults, regardless of chronological age and "youth" is defined in some countries up until 35 or 40[3] years of age.

In most countries, legislation often defines the age limits related to young people. Although the term adolescent is rarely used in legal language, prior to adulthood, a person is considered a "minor", "juvenile" or "youth". The law seeks uniformity and certainty, and rather arbitrarily selects the age at which legal adulthood is reached, commonly referred to as the age of majority. In most countries, the age of majority, defines the age at which individuals are regarded as competent to handle their own affairs. Even within countries, no universal age of majority exists for all purposes. Minimum ages often vary according to the purpose—such as marriage, civil majority, criminal responsibility, voting rights, military services, access to alcoholic beverages, consent to medical treatment, consent to sexual intercourse, etc. (Paxman, 1987, p.5)

3. WHY DEVELOP HEALTH POLICY FOR ADOLESCENTS?

Countries have demographic, social, economic and political reasons for developing policy for adolescent health. " In Latin America, demographics were primary in bringing the issue of adolescents and youth development to the political agenda of many Latin American and Caribbean countries" (Russell, 2001, p. 6). Adolescents in most regions account for approximately 20 of the world's population and 85% live in developing countries. Given their demographic importance, and their future potential, countries are increasingly interested in adolescents as a potential resource for the formation of social capital and economic growth. The period of adolescence is also an opportunity to promote healthy behaviours and prevent the onset of health-damaging behaviours that often extend until adulthood.

Some countries have used the international policy environment and international law as an impetus for developing policy for adolescents. For example, the United Nations Convention on the Rights of the Child (CRC), though formulated for children, defines young people as less and 18 years of age, thereby including the most significant years of adolescent development. The CRCs focus on children's survival, protection, development and participation adequately covers almost all grounds to ensure the

[3] Malaysia, for example, defines youth up until the age of 40. Costa Rica's Youth Law defines youth between the ages of 12 – 35 years.

" All the agencies said that the policy will enhance all their activities can serve as a guide and that in this process, the health of adolescents can be improved. The policy will also help enhance the image and credibility of the agencies involved in adolescent health activities. Being a new and sensitive area adolescent health especially reproductive and sexual health will require credible and competent policy makers and programme implementers ..."
Malaysia

child's best interest and well-being. Development frameworks are also an impetus for policy development. For example, South-Eastern European (SEE) countries, in preparation for entrance into the European Union, are faced with a series of requirements that need to be fulfilled for compliance with EU policy and legislation. Among the criteria are youth development strategies and participation in civil life which has lead to the development of youth development policies.

From a programmatic standpoint, countries are increasingly interested in developing national policy for adolescent health and development as it provides a framework for action, through the identification of common goals and national priorities that can be implemented in a co-ordinated fashion. Many countries cite that programming in adolescent health is often done in an ad hoc fashion, without co-ordination among government sector, NGO partner organizations and community stakeholders, which tends to cause overlap and gaps in programming. Countries indicate that the existence of a national policy serves to set goals for joint programming and action, sharing of responsibilities and serves as a mechanism for co-ordination. Countries also indicate that the development of policy (even after the existence of a national programme) serves to legitimate adolescent programs. In certain countries policy has led to legislation which provided a legal framework and budget for adolescent health and development.

In the Dominican Republic, youth advocates saw the absence of an overarching national youth policy as a serious obstacles to efforts to raise awareness of youth needs and to generate the political will required to pump more resources into youth programs (Rosen, 2000).

In Samoa, there are multiple donors addressing Adolescent Reproductive Health issues, sometimes in isolation of each other or one planning and implementing strategies that overlap. In the absence of resource allocation and utilization, it is important to have a policy document specifying national priorities and policies as well as providing the framework for resource allocation, collaboration and co-operation of all key funding and implementing stakeholders. --
Sydney Fa'asau, Chief Youth Officer, Ministry of Youth Sports & Cultural Affairs, Samoa

4. DOES POLICY AND/OR LEGISLATION LEAD TO IMPROVEMENTS IN ADOLESCENT HEALTH?

Countries with longstanding national adolescent health and development programs tend to have a favourable policy environment demonstrated by strong political commitment and expressed through policies and legislation for adolescent health and development. Costa Rica is an example of a country with a strong National Programme for Comprehensive Adolescent Health. In existence since 1988, the National Programme is an expression of strong political commitment by the government, which historically, has placed importance on the provision of health services for its citizens—and in the last decade has focused on adolescence. Now, Costa Rica now has strong national consensus that adolescents are priority which is demonstrated through recently passed legislation that guarantee every adolescent access to free health care.

There is little information of the impact of national policies on adolescent health and development outcomes. However, for certain health issues, a supportive political environment—as expressed through policy and legislation— has been associated with improved health outcomes.

HIV/AIDS is an area where high political commitment coupled with policies, legislation and action have led to important achievements in the fight against HIV/AIDS, as evidenced by Senegal, Uganda, and Thailand. Senegal is considered a success story in the fight against HIV/AIDS, in that it has stopped infection rates at between 1-2 percent. (link to resourse) Its low prevalence is attributed to commitment of the political, religious and community leaders, including the President and strong policies and legislation related to HIV/AIDS. This includes the legalisation of prostitution in 1969, which calls for registration and regular medical check-ups of sex workers; blood bank testing in 1970, and in 1986 created the National Committee for the Fight against AIDS, among the first in Africa, which developed the National Plan to Fight HIV/AIDS (Testimony of Ambassador Mamadou Mansour Seck from Senegal on HIV/AIDS, June 2001, Plan Strategique 2002-2006 de Lutte contre le SIDA). Senegal also has a National Council for the Fight against AIDS, which developed a Strategic Plan (2002-2006)

While Senegal is an example of how the epidemic was stopped and maintained at a low level, Uganda is an example of how the epidemic can be reversed. Uganda is one of the few countries to have subdued a major HIV/AIDS epidemic—the adult prevalence rates drop, from 8.3% at the end of 1999 to 5% at the end of 2001—with the most notable drops among the 15 to 24 year old age group. (World Bank, 2002). Uganda's success is attributed to the political leadership of President Yoweri Museveni who was among the first African presidents to acknowledge the seriousness of the AIDS epidemic and vowed to focus its efforts on fighting HIV/AIDS. The Ugandan National Task force was established in 1990 and a multisetored approach began which involved condom distribution and promotion (SIECUS, Policy Update March, 2002).

In Thailand is another example of how policy was effective in preventing the spread of HIV/AIDS. When confronted in 1988-89 with high prevalence rates among commercial sex workers (between 31% and 44% prevalence rates) and 4% among new army conscripts, the government quickly changed their policy stance and responded with a massive multisectoral response to control HIV. The result demonstrate increased condom use, up to 90% increase among men who visited brothels, a 50% decrease in visits to commercial sex workers, a 90% reduction in visits to STI clinics, and an 80% decline in new HIV infections. (World Bank, Thailand)

Price policy seems to affect certain behaviours related to health. The area of tobacco control and prevention, for example, has demonstrated clear links between policy, legislation and health outcomes—particularly with respect to youth (WHO, 1999). According to a joint World Bank/WHO report on the economics of tobacco control, "it has become clear that tax increases are a highly effective way to reduce tobacco consumption" (World Bank, 1999). The impact of price policy is likely to be greatest on young people and those living in low- and middle-income countries, as they are more responsive to price increases. Researchers have consistently found that price policy is the "single largest factor influencing short term consumption patterns, and that price plays a major role in determining how many young people will start smoking" (WHO, Mackay, J. 2002). Among average a price rise of 10 percent on a pack of cigarettes would be expected to reduce demand by about 4 percent in high-income countries and by about 8 percent in low- and middle-income countries. New Zealand, for example, adopted comprehensive tobacco control policies in 1990, and by 1996, tobacco consumption per capita among young adults (15 and older) had dropped by 21%. Thailand introduced comprehensive tobacco control policies in 1992, and smoking prevalence among Thai adolescents aged 15-19 dropped from 12.1% to 9.5%, a decline of over one-fifth. (link to resourse). Similar price policies have yet to demonstrate a link between other health behaviours, such as condom use, however, it is worth exploring the link between reduced prices of condoms and their effect on usage, particularly among young people.

5. WHAT ARE THE COUNTRIES DOING WITH RESPECT TO ADH POLICY?

The majority of countries have some type of policy or legislation related to young people. A growing number of countries have comprehensive adolescent health and development policy. Regional patterns are observed in the type and content of the national policy developed, which could be reflective of the situation of young people in the various regions as well as the political environment.

In the Western Pacific Region (WPRO), Malaysia and the Philippines have ADH policy. Vietnam and Fiji are in the process of developing ADH policy. Malaysia, the Philippines and Samoa have National Youth Policy.

ADH policies developed in the Western Pacific Region tend to have a broad health and development perspective. Sexual and reproductive health of adolescents is often not the direct focus of these policies and this may reflect the political and social climate, of the WPRO region as well as other regions, where adolescent sexual and reproductive health is a sensitive topic. However, in implementing policy, adolescent health and development program managers have a better opportunity to delve into ASRH issues.

In the Africa Region, 10 countries have policy related to adolescent health. These are: Botswana, Cameroon, Eritrea, Senegal, Burkina Faso, Benin, Malawi NYP with some health, Nigeria (ADH), Ghana ASRH, South Africa ADH, Zambia, Uganda (ADH), Seychelles YP. Tanzania is developing ADH. South Africa, Ghana and Uganda are the two countries with ADH policies. There are several other countries in the process of developing policy. For example, Burkina Faso is in the process of developing national youth health policies programs.

Countries in the Africa Region tend to have Youth Development Policies as well as Adolescent Reproductive Health Policies. Many of the Youth Development Policies developed in Africa are focused on youth participation and youth development and the

health components are limited. The health related policies for adolescents in Africa tend to focus on adolescent reproductive health, although the countries with HIV policy tend to have objectives targeted to the adolescent age group.

The SEARO Region is embarking on policy development in its member countries. To date, Nepal has developed ADH Strategy and the Regional office is supporting ADH strategies in the Maldives, India, and Sri Lanka.

In the Region of the Americas, 10 countries have policies and/or legislation related to adolescents. These are: Argentina, Brazil, Chile, Colombia, Costa Rica, Dominican Republic, El Salvador, Nicaragua, Panama and Peru. These policies are mainly ADH policy, or National Youth Policies, with a strong health component, sometimes originating within the Ministries of Health. This reflects the regions conceptual framework of development as an integral part of health. The Bahamas, Guatemala, Honduras, Haiti and Jamaica are in the process of developing or passing their policies.

European countries are focusing on National Youth Policies, with a strong focus on youth participation in social, cultural, economic and political life and youth as a "resource to society". The European Union produced a white paper entitled, EU White Paper: A new impetus for European Youth, which reflects this development focus. There is little focus on health in the white paper. Countries in South Eastern Europe (SEE) are interested in developing or strengthening youth policies in accordance with EU policies—particularly EU accession candidate countries such as Bulgaria, Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Romania and Slovakia. Romania has developed a Youth National Action Plan. Bulgaria has Youth Charter and Action Plan April 2001. Republic of Croatia is in the process of developing a National Program of Action for Youth. (link to resourse)

INSERT MAP

6. WHAT IS WHO DOING IN POLICY DEVELOPMENT?

WHO has supported several countries in the policy development process and has conducted country assessments in Haiti, Tanzania, Sri Lanka and the Philippines, whereby many of the examples from this document are drawn. The Western Pacific Regional Office has published a guide for policy-makers on adolescent health and development[4]. WPRO has also supported assessments in Malaysia, Samoa, Fiji, and Mongolia. The Africa Regional office has started a project to review ADH policy. As an initial step, it has conducted assessments of the policy situation in the Commonwealth Regional Health Community Secretariat, in Benin, Burkina Faso, Eritrea, Lesotho, Malawi, Senegal, Uganda, Zambia and Zimbabwe. The South East Asia Region is developing ADH strategy in its member countries. In India a policy review of adolescent health has been conducted and there are plans for strategy development. The Region of the Americas (PAHO) has published several documents on policy and legislation[5] [6],

[4] Policies on Adolescent Health and Development: A guide for policy-makers. WHO Western Pacific Region. Child and Adolescent Health and Development Focus. www.wpro.who.int

[5] Rodriguez-Garcia, R. Russell, JS, Maddaleno, M., Kastrinakis, M. Pan American Health Organization. W.K. Kellogg Foundation. *The Legislative and Policy Environment for Adolescent Health in Latin America and the Caribbean*, Washington, DC, June 1999.
http://www.paho.org./English/HPP/HPF/ADOL/legislative.pdf

and in particular has documents focusing on Bolivia, Costa Rica, the Dominican Republic and Nicaragua[7].

There is still little information on the policy situation with respect to ADH in many countries and WHO is in the process of better monitoring and supporting the progress in policy development and implementation.

[6] Morlachetti, A. Obligaciones de Latinoamerica y el Caribe ante el derecho internacional de adolescentes y jovenes. Con revision de los documentos actuales. March 1999. (Spanish only) http://www.paho.org./Spanish/HPP/HPF/ADOL/situacion.pdf

[7] Adolescent and Youth Policy: The Experiences of Colombia, Dominican Republic and Nicaragua. PAHO. Adolescent Health and Development. April 2001. http://www.paho.org/English/HPP/HPF/ADOL/YouthPolicy.pdf

Part II. Developing National ADH Policy

Overview: Diagram II below highlights the key steps taken in several countries, organized into four phases[8]. It is important to keep in mind that the process does not have to follow a structured sequence and the various steps within each phase can be utilised out of sequence.

Countries have indicated that it is not possible to make any recommendations on the length of time any specific step will take, as it the policy development process depends on factors that will be described in more detail in a later section. Advocacy, communication, and the involvement of young people are considered both steps in the process as well as an approach that should be continuously integrated throughout the process.

PHASE I: ASSESSMENT AND PREPARATION

The first series of steps (advocacy, youth and adolescent involvement, analysis of policy environment, identify stakeholders, create a multisectoral mechanism, situation analysis) do not necessarily need to occur in that sequence, as a few countries have demonstrated. For example, some countries have conducted an analysis of the situation before creating a task force. However, it is agreed that the first series of steps should occur prior to setting goals and objectives for a policy.

1.1 Advocacy and communication

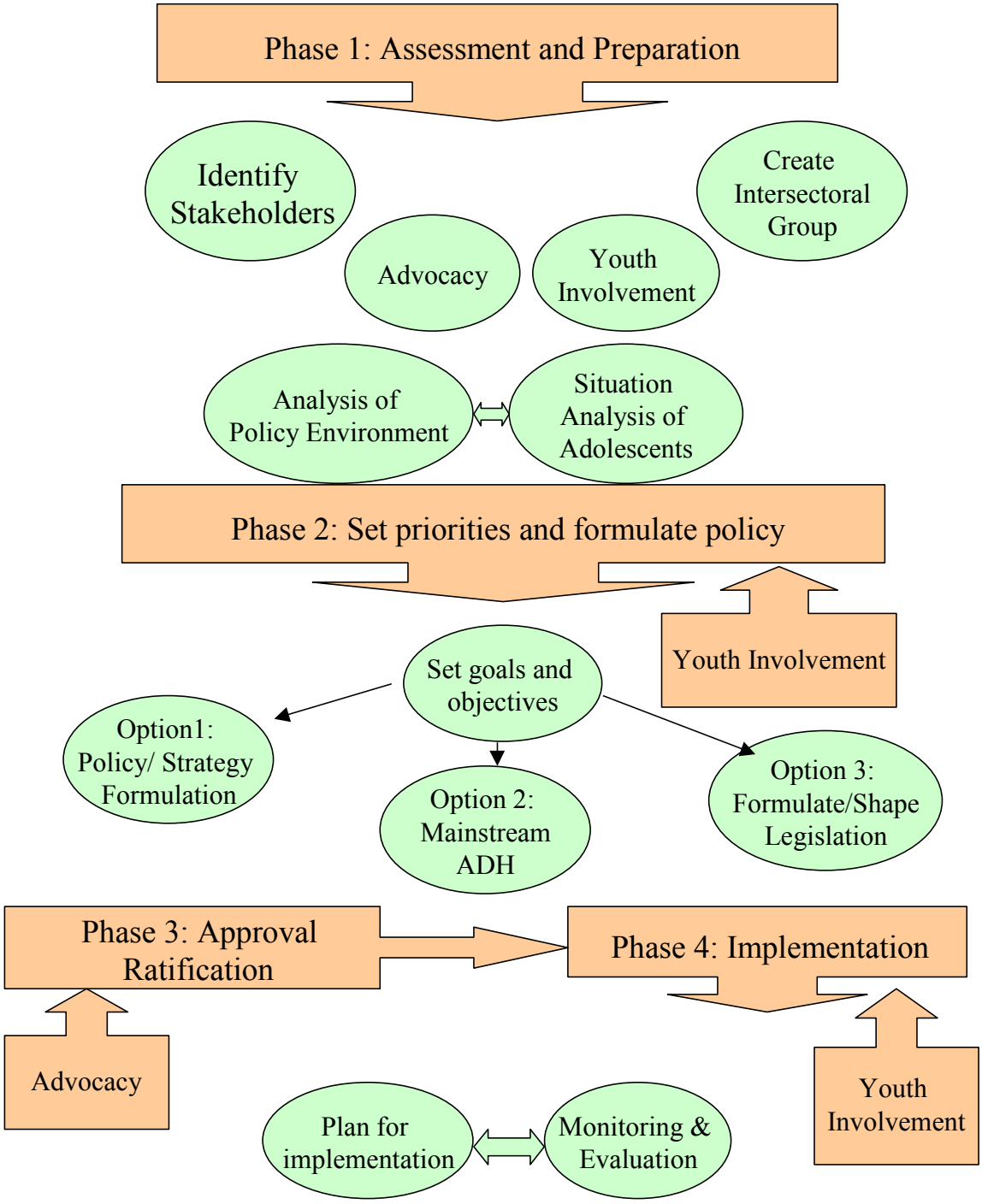
Advocates for Youth, a US based NGO, defines advocacy as actively supporting a cause and getting others to support it as well. Making the case in favour of a particular cause and using skilful persuasion and/or strategic action. Involves attempts at influencing political decision-makers, general public opinion in favour of adolescent health and development. (advocates, 1995). For the purposes of this document, advocacy includes communication and sensitization.

Advocacy and communication are key to the policy development process. The decision for a government to embark on policy development usually stems from an advocacy and communication process. For example, it may stem from youth or student movements or it can stem from an external factors such as the ICPD as in the case for several countries that developed Adolescent Sexual and Reproductive Health Policy (as in the case of Ghana,) or from high profile politicians, such as the First Ladies in several countries.

The point is that advocacy, communication and sensitization or education to influence public opinion, policy makers and program mangers are key to mobilizing the resources and political commitment necessary to initiate the policy development process and see it through to its official adoption by the government.

[8] Assessment documents from Sri Lanka, Fiji, Haiti, and Tanzania

Diagram II: Process for Developing National Policy



Opportunities for Advocacy:

- ✓ International or national campaigns such as World Youth Day, World AIDS Day, etc
- ✓ National Youth Week, Youth Fair
- ✓ Municipal, Community festivals, fairs
- ✓ Television, radio messages and advertisements
- ✓ Meetings with various ministries
- ✓ Visits to community projects and activities

Advocacy Strategies

- ✓ Convene meeting with Minister of Health, Youth, Sports, Education in order to gain their commitment to policy development and youth programming
- ✓ Sensitize stakeholders on importance of policy and the policy environment, including any international agreements to which the country is signatory
- ✓ Share results of situation analysis with decisions makers, community leaders and general public through the media
- ✓ Find an influential representative with high visibility (media, political, sports arena) to promote messages and move agenda forward
- ✓ Establish a network of journalists "friendly to adolescent health and development"
- ✓ Keep stakeholders abreast of issues that concern youth through an information network (newsletter, meetings, e-mail)
- ✓ Use current events to launch the topic of youth and development (sexual violence trends, youth in the labour force, youth representatives as community leaders)
- ✓ Ensure clear, consistent advocacy messages are consistent (don't mix the message)
- ✓ Youth as partners in advocacy strategies

In the case of the **Dominican Republic**, the policy initiative received attention from the President and Vice-President that personally endorsed the formation of a Directorate to Promote Youth, which was housed within the Office of the President, and not within a particular ministry. The First Lady of the Dominican Republic also served as a representative to lead advocacy efforts to get the media involved and interested in youth and helped jump start the policy development process and bolstered commitment among stakeholders. High profile political leaders were cited as being key to ensuring that the Policy was approved and later turned into legislation. (Rosen, 2000)

Key resources:

1. PAHO/Advocates for Youth. *Guía para abogar por la salud integral de los-las adolescentes, con énfasis en la salud sexual y reproductiva*.
2. Advocacy Kit: *Adolescent Sexual and Reproductive Health***.** Advocates for Youth, July 1996.

How to ensure youth participation:

- ✓ Provide a role for young leaders in the committee to develop policy
- ✓ Consult the work of youth organizations when drafting policy documents
- ✓ Organize a forum to identify adolescent concerns
- ✓ Consult documents from youth organizations to include their perspective

Who to include?

- ✓ Young leaders in community and religious organizations
- ✓ Adolescents and youth in media or sports
- ✓ Adolescents and youth in political organizations
- ✓ Youth service organizations (Scouts, Red Cross, Rotary)
- ✓ Young people working in youth serving organizations
- ✓ University and other students

1.2 Involvement of Young People

In order for an adolescent policy to adequately address the needs of young people, their needs, concerns and enthusiasm needs to be taken to the policy level. Young people are strong advocates and social actors for setting policy goals and objectives. Like advocacy and communication, the involvement of young people is key and should be integrated throughout the policy development process. Youth movements in West Africa, Central America, Europe and other regions have led to National Youth Policies and Regional Youth Summit Declarations.

Involvement of young people means having them as partners in the process and ensuring their perspective is integrated into policy goals and objectives. It is important to identify needs and concerns of adolescent from their perspective, as it can be quite different from those identified by national surveys or program planners. For example, youth declarations often cite education, employment and constructive recreational opportunities as top priorities, whereas national surveys often cite adolescent pregnancy as a key issue. It is important to take both into consideration.

There are some challenges to the participation of young people, as they are sometimes used as tokens, rather than considered active participants. There is still resistance towards working with young people as it is felt that they do not have enough experience, or they have other priorities, and drop out rates are high. Experience has shown, however, that programs that include the participation of young people are more successful. Those that are resistant may not have defined roles suitable to young people (Advocates for Youth, 2001).

Involvement of Young People in Haiti

Through a series of Youth Congresses, organized by the Ministry of Education and Ministry of Health, youth representatives from each department articulated their needs and proposed solutions to the issues concerning their lives. The purpose of the Youth Congress was to come up with a resolution to propose to the Haitian Parliament. Young people outlined the following areas of concern, in order of importance to young people:

- Unemployment and lack of income generating activities
- Environment and sanitation
- Lack of recreational activities
- Inadequate educational system
- Poor sexual and reproductive health outcomes
- Injustice and inequity in gender relations, family environment

The Youth Forum revealed that youth priorities are slightly different from the programming environment, which focuses on sexual and reproductive health, which, although a concern, was not one the top priority for young people. Young people concerns contributed to the lines of action for the draft National Policy for Adolescent Health and Development

Key Resources:

1. Advocates for Youth. Community Participation Partnering With Youth: A Rights, Respect, Responsibility Paradigm. Volume 14, No 3. April 2002.
2. Advocates for Youth. Youth Involvement in Prevention Programming. Advocates for Youth. August, 2001.

1.3 Identify Stakeholders

Stakeholders can play a key role in pushing the policy development agenda forward. Intersectoral co-ordination and investments on the part of the key stakeholders will ensure the application of the policy in the programming arena. As a first step, identify all the stakeholders involved in adolescent health and development in order to sensitize them to the need for developing a policy. Countries indicate the importance of inviting all main stakeholders from the beginning of the process—so as not to leave out any key stakeholder groups that can play an important advocacy role in favour of policy development.

Once the stakeholders are on board, it may be more productive to establish a smaller working group or task force to actually formulate the policy. When narrowing down the group of stakeholders, it is important to consider who are the main social actors in terms of advocacy for adolescents. In certain countries, student movements and civil society are key social actors in influencing adolescent policy.

Who are the potential stakeholders?

- ✓ Youth serving NGOs
- ✓ Youth groups
- ✓ Service providers
- ✓ Politicians
- ✓ Universities
- ✓ Government Ministries (health, education, population, youth, labour, social affairs, justice, etc)
- ✓ Community groups (parents, teachers, religious leaders, community leaders)
- ✓ International agencies
- ✓ Business/private sector (ones that target youth market)
- ✓ Media (television, radio, print that market youth, or that are youth friendly)

Purpose

- ✓ Share information on who is doing what
- ✓ Share knowledge and data on ADH issues
- ✓ Share common messages
- ✓ Know to whom to target advocacy activities
- ✓ Know who can contribute to policy development

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results
political importance
ability to reach out to

key stakeholders at an early stage of development to gain support not only for the development of the policy but also for the implementation of the policy once it has been developed – *Samoa*

1.4. Create Multisectoral Mechanism

Key stakeholders should be invited to take part in the policy development process. The launch of the process by a high level political official lends greater leverage to the process and demonstrates the government's political commitment. The First Ladies in several Latin American countries have offered support to this area.

A formal mechanism such as a working group, committee, or task force should be established with bylaws and work plans for developing the policy, including its implementation and adoption. There may already exist some type of multisectoral committee that meets on issues related to adolescent health and development. For example, many countries have an adolescent sexual and reproductive task force or a UNAIDS task force with a subcommittee on adolescents. If this is the case, it may only be necessary to review the existing committee by inviting additional stakeholders to participate in the policy development process.

The process may be co-ordinated by one ministry, however, in order to ensure equal ownership of the policy document, stakeholder groups may find it useful to set up a formal mechanism so each stakeholder has a role in the process, based on the comparative strengths of each stakeholder group. For example a research organization could provide data on a particular issue, while a youth organization could provide useful insights into various adolescent group perspectives.

Main Activities:	Purpose
✓ Hold orientation meeting with stakeholders to sensitize them to the importance of a policy as a part of their commitment to adolescent rights ✓ Ensure representation from stakeholder groups ✓ Provide stakeholders with assessment of the policy environment ✓ Formalise the mechanism ✓ Set timeline for policy development ✓ Establish next steps, human resource commitments, and distribution of responsibilities among each organization ✓ Establish a smaller task force for the actual policy development	✓ Build consensus among key stakeholders (including youth) on priorities for adolescent health and development ✓ Identify the common agenda for youth ✓ Develop policy goals and objectives ✓ Write, review and edit policy ✓ Advocacy towards policy development, adoption and implementation ✓ Share information with others

1.5. Assess the Policy Environment --Review existing policies and legislation

It is likely that some form of policy or legislation exists in most countries. An assessment of the actual policy environment is a necessary first step for a country to determine where to focus its efforts.

This document will not describe in detail the methodology for assessing the policy environment, as there are documents, which describe this process (see key references below). The extent to which the assessment will analyse existing policies depends on human and financial resources and time available to do so. Conducting an assessment of the policy environment implies a review of existing national policies (in areas related to adolescent health and development) and reviewing national laws, regulations and policies related to adolescents. It would be important to examine the purposes, goals, objectives and contents of existing policies, in relation to each other in the case of policies from various sources and sectors. The review would also include looking at whether a given country is signatory to any international agreements and treaties. Look at existing development frameworks being promoted by the various international agencies such as the World Bank and IMF's Poverty Reduction Strategy and the UN Millennium Development Goals.

Part of the policy environment assessment includes looking at the political, legislative and judiciary systems in place. For example, what does it take for a policy to become officially adopted by the government? How have past policies been formulated? What does it take to change existing policy? What role do the judiciary and legislative systems have in policy approval, and ensuring its implementation? What does it take to pass legislation? How is legislation enforced? What process is required to change legislation? How does legislation get formulated? Such systems also influence the policy development and implementation process.

Sources of Policy: Where to look

- ✓ Review the government's constitution, executive decrees, administrative regulations, government programme statements, development plans and statements of officials.
- ✓ Review existing policies from other sectors, policy statements, ministerial decrees from various ministries to review their perspective on ADH
- ✓ Review existing legislation, judicial decisions, legal opinions related to adolescents
- ✓ Look at government allocations assigned to adolescent health and development.
- ✓ What civil and political rights are respected
- ✓ Which international or bilateral donors are working in ADH and what types of activities and programmes they support
- ✓ Review public opinion (print, media, public statements) and its influences on the existing policy environment
- ✓ Talk to people involve in adolescent health and development issues

Key Resources:

1. Coming of Age: from facts to action on adolescent sexual and reproductive health
2. Futures Group, Policy Project. Policy Environment Score.
3. PAHO. The Legislative and Policy Environment for Adolescent Health in Latin America and the Caribbean.

Adolescent health and development at the International level

International Treaties: All countries (with the exception of two) have signed and ratified the Convention on the Rights of the Child (CRC), making it the most widely ratified human rights convention and the first international instrument which covers the full rights of an individual. The Convention defines the "Child" up to 18 years of age, and therefore includes the adolescent. The signing and ratification of this document provides a common legal framework to increase accountability, develop National Policy, bring about legislative reform and ultimately create a safe and supportive environment for children and adolescents.

Any policies, legislation or programming should ensure that the four main principles of the Convention are integrated. When a country signs and ratifies the Convention they are obligated by international law to report on the implementation of the Convention. The Articles of the Convention are underpinned by four guiding principles which are:

- The right to life, survival and development (article 6)
- Take the best interests of the child (and adolescent) as a primary consideration when authorities of a State take decisions. (article 3)
- The right of the child (adolescent) to express their views freely on all matters affecting them (article 12)
- Ensure non-discrimination of every child (adolescent) (article 2)

International Policy: The UN has sponsored international consensus building conferences where countries are signatory to certain agreements. The main agreements affecting the policy environment for young people are The International Conference on Population and Development (ICPD) and the Fourth World Conference on Women, which led to the Beijing Platform of Action and the UN Special Session on Children

(SSOC). These agreements are not legally binding, but countries that are signatory have indicated their agreement to abide by its principles.

The official outcome document approved at the ***UN Special Session of the General Assembly (SSOC)*** on Children on 10 May 2002 articulates the goal to develop and implement policies and programme for children, including adolescents, in the areas of: improving access to information and services, combating HIV/AIDS, prevention of narcotic drug use, substances and inhalants, tobacco use, reduction of violence and suicide, reduction of exposure to harmful environmental contaminants, prevention of violence, neglect, abuse, malnutrition, support access to education and participation in civil society.

These international treaties and agreements provide a common legal framework from which countries have agreed to abide. (link to resourse)

Policy assessment at the national level

A series of scenarios are presented below to describe the current policy situation of countries with respect to adolescent health and development at the national level. Recognizing that countries are varied, the scenarios are a simplification of characteristics to identify where a country stands and which policy option has been taken to advance adolescent health and development in the country. The scenarios are not exhaustive and no country will fit one scenario entirely. The scenarios are taken from existing policy development processes and can serve as examples to countries with a similar policy environment.

Scenario 1: Existence of health-issue specific policies, which do not target adolescent age groups. This scenario describes a country where there is no national adolescent health and development policy. There is health issue specific policy or policies, but which do not focus on adolescent age groups. Many countries, for example, have reproductive health policies, or HIV policies that may or may not integrate adolescent health concerns.

Existence of Health Issue Specific Policies but none specific to ADH: Haiti and Nepal

At the time of policy development, neither Haiti nor Nepal had national adolescent health program. Activities and adolescent health services were run through small- scaled NGO projects and were not well co-ordinated among the various ministries or NGOs working in adolescent health and development. Neither country had specific laws related to ADH (PAHO Evaluation, Nepal policy document).

Haiti has a draft National Population Policy as well as a National Health Plan but adolescent health and development concerns were not integrated. Both Ministries recognized the importance of Adolescent Health and Development to accomplishing its national health goals. Haiti set out to develop comprehensive National Adolescent Health and Development Policy, whereas Nepal developed National Adolescent Health Strategy, which includes work plans outlining the roles and responsibilities of stakeholders for implementation of the strategy at the national, district and municipal levels. In both countries, the documents have not yet been approved.

Scenario 2: Existence of national policy related to adolescents, but health not sufficiently addressed. This scenario describes a country where there is national policy related to adolescents, but no national policy that includes ***both*** adolescent health and development. For example, several countries have National Youth Policy (NYP) which focuses more on adolescent participation in civil life. Some NYP include adolescent health with a development approach, but some do not.

Existence of National Youth Policy and Development of Adolescent Reproductive Health Policy: Ghana

In 1996, the Ghanaian National Population Council developed a draft Adolescent Reproductive Health Policy. The policy environment in Ghana was such that it was signatory to the ICPD Programme of Action (Sexual and Reproductive Health and Rights framework) and the National Youth Council had developed its National Youth Policy (1996). The National Youth Policy focused on youth participation in civil society, civil rights and responsibilities, with few links to the sexual and reproductive health issues relevant to young people aged 10-24. The Ghana Adolescent Reproductive Health Policy became official policy of the Government of Ghana in October 2000.

The Adolescent Reproductive Health Policy, focuses on young people between the ages of 10-24 years and reflects on the ICPD Programme of Action as well as the National Population Policy of 1994 (National Population Council, ARH Policy document, 2000).

Why did Ghana develop an ARH policy when there was a NYP policy? The Adolescent Reproductive Health Policy has its focus on adolescent sexual and reproductive health and includes a broader approach. The Policy includes a multisectoral approach and includes areas such as education, communication, and youth development. The ARH Policy also makes explicit links to the National Youth Policy, the HIV/AIDS Policy, the National Population Policy as well as the National Constitution and has the goal of strengthening linkages among Government Ministries such as the Ministry of Manpower Development and Employment, Ministry of Youth and Sports and Ministry of Rural Development and the Law Reform Commission, Ministry of Communications and Media. The ARH Policy recognizes that the Ministry of Youth and Sports and its draft Youth Policy is the official body responsible for young people and the ARH Policy calls for integration of adolescent reproductive issues into the Ministry of Youth and Sports Programs. The two policies complement each other to encompass a health and development framework although issues such as mental health, nutrition and substance use are omitted from the existing adolescent policies.

Developing National Health Issue Specific Policy
Currently, Ghana is in the process of adopting its draft HIV/AIDS Policy that focuses on reducing HIV infections among the 15-49 age group and mentions a focus on "other vulnerable groups especially youth". Although this policy is in draft form, the Ghana AIDS Commission, created by the President in order to address HIV/AIDS, is being implemented through the Ghana HIV/AIDS Strategic Framework 2001-2005.

Ghana is in a position where it has a policy environment favourable to adolescent health and development. Although Ghana does not have an explicit Adolescent Health and Development Policy, ADH issues are integrated into the Adolescent Reproductive Health Policy and the National Youth Policy. Its role now is to ensure the integration of ADH issues into the formulation of future policies and legislation related to young people. An example would be to integrate adolescent health and development into the existing HIV/AIDS policy that will shortly be approved by the Government of Ghana.

Existence of National Youth Policy and Integrating ADH into existing policy: Fiji

In March 1999, A National Youth Summit was held to approve a draft National Youth Policy prepared by youth organisations, government and civil society stakeholders. Upon approval at the Summit, the draft national policy was formulated for submission to Cabinet for official adoption by the Government of Fiji.

The Ministry of National Planning is responsible for the development and implementation of national policies which are incorporated into the Ministry's Strategic Development Plan 2002-2004, which amalgamates related policy objectives from various ministries. Concern was raised that the National Youth Policy was not fully vetted by all stakeholder groups and as a result some issues, such as adolescent sexual and reproductive health were not adequately addressed in the document. The draft National Youth Policy included health, but only with respect to prevention of STIs and HIV. It was suggested that the Ministry of Health work closely with the Ministry of Youth, Employment Opportunities and Sports to integrate additional ADH issues into the existing draft National Youth Policy (such as nutrition and mental health) rather than formulate a separate Adolescent Health Policy.

Further consultation could result in a single National Youth Policy that more comprehensively targets the broad spectrum of health and development needs of young people than separate sub-sector policies. This collaboration is currently being considered. (Fiji assessment, March 2002)

Malaysia: Existence of National Youth Policy and Development of ADH Policy

Malaysia has an active Youth Council that is responsible for adopting two National Youth Policies—the first National Youth Policy approved in 1985 and the new National Youth Development Policy, launched in 1995. The National Youth Development Policy focuses on empowering youth to be agents of change in civil society. The MOH had begun providing adolescent health services as part of their expansion of the basic package of primary health care. The NYP includes links to health, but is not directly addressed, therefore a gap in health issues was identified in the National Youth Policy and the MOH set out to develop National Adolescent Health and Development Policy.

The Malaysian ADH Policy includes objectives to promote adolescent resiliency, participation, and healthy lifestyles, and to prevent risk behaviours. It includes strategies for health promotion, accessible and appropriate health services, human resource development, adolescent health information system, research and development, strategic alliances, and legislation.

In October 2001, The Malaysian Ministry of Health launched its National Adolescent Health Policy. Malaysia is in the process of developing a plan of action for implementation of the policy.

Scenario 3: Existence of Implicit Policy through a National Programme. Describes a country where there is programming on ADH, through a National Adolescent Program. In such a case, policy issues are addressed implicitly, through norms, regulations and standards applied in practice. In this scenario, there is no explicit national policy on adolescent health and development.

A National Adolescent Health Programme implicitly brings with it a structure which promotes adolescence as a unique, individual population. Such a system facilitates the introduction of new policies, which were previously without context and consequently not considered. A national programme can introduce adolescent policies and legislation and provide a framework to which other policies and legislation can adhere.

Costa Rica Case: National Programme -> National Youth Code -> Legislation

Costa Rica is a pioneer in terms of taking on a comprehensive adolescent health and development approach. Since 1989, Costa Rica has had an Integrated National Adolescent Health Program (PAIA) coordinated by Social Security and the Ministry of Health. Prior to this, the health needs of adolescents were addressed within the context of either adult or child services, mostly within schools. A small group of advocates that pushed for a more integrated approach to health and development were able to change Costa Rica's traditional approach to adolescent health.

Costa Rica is an example of a country that has a National Programme (implicit policy), and a General Law for Young People (Ley General de la Persona Joven) passed in May 2002, which includes a series of laws that protect minors and stipulate the rights and responsibilities of young people. Costa Rica has a solid Costa Rica's Youth Code provides the legal framework for institutionalising youth, through the establishment of a Vice-Ministry of Youth, which is responsible for policy and legislation related to adolescents and youth. Costa Rica has a strong legal framework which has resulted in several laws in relation to adolescents and youth. Most of these laws stipulate youth as subjects with rights and responsibilities and encourage their participation in civil society.

As the Adolescent Health Program has been in existence for several years, it is well known throughout the country and remains a stable institution somewhat immune to political changes. The program has recently (April 2002) documented its program vision, mission and strategies, which in effect can be considered its policy document. The program leverages its legal and constitutional framework to ensure that adolescents and youth have access to youth friendly services.

Key resources:

1. The Legislative and Policy Environment for Adolescent Health in Latin America and the Caribbean, PAHO, June 1999.
2. Krauskopf, Dina. La Construccion de Politicas de Juventud en Centroamerica. Asesora Vice Ministro de Juventud de Costa Rica.
3. WHO. Role of Policy in the Context of National Adolescent Health Programmes: Review of National Adolescent Health Programmes in Brazil and Costa Rica. Hanson, Christy. 1996.

Before deciding on which policy option to take (Phase II), it may be important to first look at the health issues affecting adolescent in the country through an analysis of the situation.

1.6 Conduct an Analysis of the Situation of Adolescents

In order to set policy goals, objectives and priorities that will adequately respond to the issues that affect adolescents, an assessment of the situation and needs of adolescents is necessary. This is complementary to the assessment of the political environment, which assesses gaps in policies and legislation, while the situation analysis would identify gaps and needs in services and programming. The results of both should be reviewed jointly to set priorities and identify approaches that the national policy would aim to address.

Conducting a situation analysis has cost implications. Although this may be a cost attributed to policy development process, it is an endeavour that is also important to programming on adolescent health. It may not be necessary to gather primary data on ADH as many of the stakeholders may have useful information and documents that will help set the stage in terms of establishing the main issues concerning adolescents. Several of the stakeholder may have conducted small-scaled evaluations which can provide a picture (although perhaps fragmented) of the situation of ADH in a particular region, district, or sector.

A diagnostic can also be a useful advocacy instrument for policy makers and the community to know the situation of adolescents. If funds are available the situation analysis can be written up for distribution throughout the country, so that data is consistent and known by the major stakeholders. Also the situation analysis results should be shared with political leaders and media so that the public knows the situation of adolescents and the main issues facing young people in the country. The information gathered through the analysis will also prove to be a powerful advocacy tool that can be used to persuade decision-makers and organizations of the need to develop a policy.

Key Resources:

1. Giving Adolescents a Voice: a Rapid Assessment of Adolescent Health Needs, 2001. WHO, Manila.
2. A Guide to Monitoring and Evaluating Adolescent Reproductive Health Programs. 2000, Focus on Young Adults, Washington.

Key sources of information

- ✓ National surveys and surveillance data
- ✓ Program or project surveys
- ✓ Existing policy documents
- ✓ Service statistics or records (hospitals, clinics)
- ✓ Police statistics (crime, drug use, violence)
- ✓ Documents with youth perspectives (Youth Declarations)
- ✓ International organization publications (WHO, UNFPA, UNICEF, ILO, etc.)
- ✓ Project assessment reports and evaluations
- ✓ Interviews with key programmers, etc.

What to look for

- ✓ National data disaggregated by adolescent and youth age groups
- ✓ Major causes of morbidity and mortality
- ✓ Rural versus urban discrepancies
- ✓ Youth needs and perspectives
- ✓ Risk factors or protective factors
- ✓ Knowledge, attitudes and behaviours
- ✓ Prevalence, incidence, trends
- ✓ Analysis by age and sex and other characteristics (married, unmarried)
- ✓ Regional, district, and municipal level data

Types of services available for youth

- ✓ Who is doing what
- ✓ Gaps in programming (violence, gender issues, substance use)
- ✓ Duplications in programming
- ✓ Comparative advantage of stakeholder groups

What to do with information

- ✓ Share with stakeholders
- ✓ Share with policy makers
- ✓ Set priorities for policy making
- ✓ Disseminate to media to influence public opinion

Areas for inclusion General Country Data

Socio-economic

- ✓ Adolescents as percentage of population
- ✓ Rural versus urban
- ✓ Average age at marriage
- ✓ % of adolescents working
- ✓ Share of household income
- ✓ GNP per capita

Health

Sexual and Reproductive Health

- ✓ Adolescent pregnancy
- ✓ Sexual debut
- ✓ STI prevalence
- ✓ Condom use
- ✓ Awareness of SRH behaviours
- ✓ Sexual abuse and coercion

Mental Health

- ✓ Depression
- ✓ Suicide rates
- ✓ Eating disorders

Substance use

- ✓ Tobacco use
- ✓ Alcohol use
- ✓ Illicit drug use; type of drugs used HIV/AIDS
- ✓ HIV prevalence in adolescent age groups
- ✓ Orphans due to AIDS
- ✓ Knowledge and behaviours

Nutrition &

- ✓ Nutrient deficiencies
- ✓ Over- and underweight
- ✓ Physical activity

Violence& Injury

- ✓ Adolescent victims of violence
- ✓ Adolescent perpetrator of violence
- ✓ Accident

Development

Education

- ✓ % of adolescent in school
- ✓ adolescent literacy rates
- ✓ % of adolescent at secondary, university level

Protective Factors/Risk Factors

- ✓ Adolescents living with both parents
- ✓ Adolescent "connectedness"

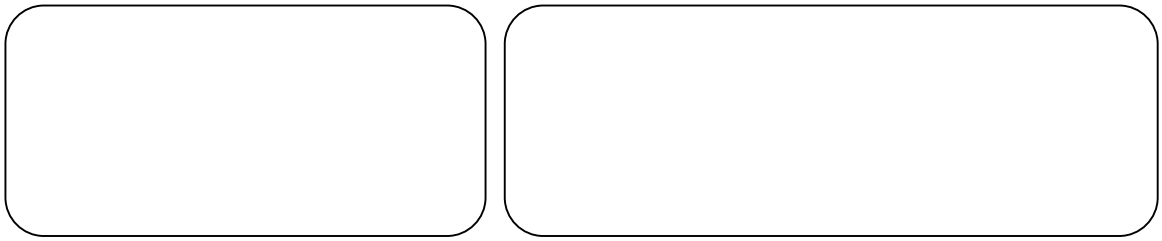
Participation of young people

Recreation

The priority for ADH will be given to problems which face a large proportion of adolescents and those which are feasible to implement with available resources. *Nepal Strategy assessment.*

Priorities for adolescent health were identified through the National Health Priority Plan which outlines maternal mortality and HIV and key problem areas for the Ministry of Health. Adolescents and youth are key to achieving national health priorities. *Ministry of Health, Haiti*

Once there is a multisectoral committee, an assessment of the policy environment and the health and development situation of adolescents in the country, the groundwork has been set to decide on a policy option, set priorities and formulate policy.



2.1. Deciding on a policy option

From the country assessments reviewed, it is observed that most countries typically consider three areas for policy development. These are presented as options a country may wish to consider. The purpose of this document is to support national program managers to develop policy. Developing policy requires high level political commitment, financial and human resources, strong coordinated efforts among partner organizations working on ADH issues and the process.

Option 1: Develop National Adolescent Health and Development Policy. Increasingly, countries are interested in the development of National ADH Policy, and WHO has supported several countries, such as Bolivia, Dominican Republic, Haiti, Malaysia, Maldives, Nepal, Philippines, Sri Lanka and Tanzania in this effort.

For a **country that has health issue specific policy, that does not target adolescent age groups**, it may be of benefit to develop ADH policy. In such a case, a National Adolescent Health and Development Policy would serve to streamline adolescent health issues that may exist in different health-issue specific policies into one comprehensive policy document. This could improve co-ordination and contribute to a common vision among the various stakeholders. In addition, developing an ADH policy can have budget implication, as one co-ordinated policy approved by the government may be entitled to its own budget and can mobilize resources to support its activities. In the case of Haiti, it has contributed to the leadership of the Ministry of Health with respect to adolescent health and set the foundation for resource mobilization for establishing a national program.

For a **country that has national policy related to adolescents**, (such as an ASRH Policy or a National Youth Policy), it may still be beneficial to develop ADH Policy under the following conditions:

If ASRH policy is narrowly defined and does not include strong linkages to adolescent development and broader health issues such as schooling, nutrition, mental health, and substance use, it would be important to consider these issues as they relate to adolescent sexual and reproductive health.

Tanzania- Move from ASRH to ADH

Tanzania has developed a National Strategy for Adolescent Health and Development 2002-2006, which is a follow up to the strategy for Reproductive Health and Child Survival 1997 – 2001. Tanzania moved from a reproductive health focus to a broader adolescent health and development strategy in order to better address the multiple health and development needs of adolescents. The original incentive to develop policy was linked to the ICPD framework. The situation analysis conducted in Tanzania identified additional adolescent health needs such as malaria, TB, mental health, substance abuse and gender based violence. Therefore, Tanzania took on a broader approach.

The overall goal of the strategy is "to improve the overall quality of life and well being of adolescents in Tanzania". Tanzania took on a broader approach which includes the following six areas:

- the promotion of adolescent's general health status, especially SRH, nutrition, mental health and other endemic diseases;
- provision of a basic minimum package of high quality adolescent friendly health services;
- the development of life and livelihood skills for income generation;
- prevention of STIs including HIV/AIDS and care of those infected;
- the protection of adolescents' rights;
- the promotion of positive attitudes and behaviour change of adolescents towards health and development.

If there is a National Youth Policy but it does not consider issues such as sexual and reproductive health, including HIV/AIDS prevention, mental health, and substance use, these issues could be included in an ADH policy. Countries such as Fiji, Ghana, Malaysia and South Africa have developed ADH policy despite having a National Youth Policy. There should, however, be mechanisms to ensure coordination between the two policies. As in the case of Ghana, where an ASRH policy was developed to supplement the NYP, the policy encourages collaboration between the two sectors for the implementation of the policies.

However, if adolescent health and development issues are adequately addressed in the existing policies (or if there is both an ASRH and a National Youth Policy) it may not be necessary to develop a new Adolescent Health and Development Policy, but rather ensure coordination among sectors in the implementation of policy through integrated programming.

A **country that has national program, but no national policy**, may want to develop National Adolescent Health and Development Policy. This could lead to more strategic programming. A national policy could serve to improve co-ordination, and programming through the commitment of the government to adolescent health and perhaps the allocation of financial resources to implement the policy.

National Youth Policy - National Adolescent Reproductive Health – Adolescent Health and Development Policy
What are the differences?

Adolescent Health and Development Policy aims to bridge development and health from a health perspective, recognizing that the behaviours that lead to various health outcomes are often interrelated and linked. An ADH Policy reflects the conceptual framework for adolescent health and development presented at the beginning of the document.

The difference between a National Adolescent Health and Development Policy and a National Youth Policy is subtle yet important. A adolescent health and development policy is one that deals explicitly with health issues, and typically include other sectors as they relate to adolescent development. A youth development policy has explicit links to education, skills development, labour, and socio-political participation, but the link to health may only be implicit. Usually a Youth Development Policy is spearheaded within the Ministry of Youth, Sports, or perhaps the Ministry of Education. The actual ownership of the policy is important as there often exists a hierarchy of ministries in governments, where some ministries have more importance (and higher budget allocation) than others. If a youth development policy explicitly addresses health issues, it may be sufficient.

An adolescent health and development policy would focus on the age group 10-19 years (although some extend to 24 years, but usually not beyond 24 years).

A ***National Youth Policy*** defines role of youth in society, and the responsibility of society to youth, based on a vision of and by youth of that present and future society. It considers the needs, problems and aspirations of youth and integrates a gender approach to promote equal opportunity for young women and young men. It ensures their economic inclusion, their civic, social and cultural participation and protects them from exploitation and neglect (ICNYP, 2001, Kenyon, 2002). The age range for youth policies varies across countries and the older age limits can span from 30 to 40 years, depending on how a country defines "youth".

Adolescent (Sexual and) Reproductive Health Policy The 1994 ICPD Programme of Action raised countries awareness of the reproductive rights of adolescents. The Programme of Action calls for attention to adolescent sexual and reproductive health issues, such as unwanted pregnancy, unsafe abortion and sexually transmitted diseases, including HIV/AIDS through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically for adolescents. Countries have since developed policy to protect and promote the rights of adolescents to reproductive health education, information and services which focus on responsible sexual behaviour, including family planning, family life education, sexually transmitted infections, HIV infection and AIDS prevention, gender relations and equality, violence against adolescents and prevention and treatment of sexual abuse and incest. ASRH policies may have links to broader health and development issues as they relate to SRH, such as education, nutrition, and perhaps substance use, but rarely have links to mental health.

Option 2: Mainstreaming adolescent health and development issues into existing policy and legislation processes. The policy environment may be such that developing National ADH Policy is not feasible. A second option to developing ADH policy would be to focus on mainstreaming ADH into existing policy and legislation processes. This includes mainstreaming ADH into broader global development frameworks such as the Millennium Development Goals (MDGs), Poverty Reduction Strategy Papers, the UN Development Assistance Frameworks (UNDAF) frameworks and Health Sector Reform (HSR), and the Stability Pact for South-Eastern Europe. Such

Mainstreaming is essential. Experiences clearly demonstrates that isolated, single-sector interventions are not effective in addressing ADH concerns: mainstreaming adolescent health and development in ***all*** sectors is essential to achieving ADH outcomes and to realizing national development objectives. *Fiji*

frameworks are increasingly important instruments in developing policy (UNFPA, 2002). These frameworks have several objectives that are related to young people and program managers and advocates for ADH are struggling with ensuring that adolescent health and development concerns are being properly integrated into such global strategies and policies.

The UN International Conference on Population and Development has been a catalyst for countries in formulating and adopting sexual and reproductive health policies, as well as adolescent sexual and reproductive health policy. Similar, the surge of the HIV epidemic have prompted countries to develop National HIV policy, often with strategies for prevention among adolescents and youth. It is important to ensure that adolescent health and development is integrated into such policies. Things to consider include, whether the existing issue specific policies are of relevance to adolescents in the country. For example, if maternal mortality is high, and a large percentage of maternal deaths are to adolescent girls, then it would be important to ensure that adolescent concerns are integrated into a reproductive health or maternal mortality reduction policy.

The integration of adolescent health and development into existing issue specific policies, such as HIV/AIDS, reproductive health, etc. is strategically important, particularly if there is an issue of relevance to young people and has the political commitment necessary to develop policy. For example, given the trends of HIV infection among young people, adolescent health and development into an HIV policy process would be crucial to meeting any objective of lowering overall HIV infections rates in a given country. By contributing to that process, it is possible to ensure that adolescent health and development is not marginalized.

The strength of this option is that adolescent health (particularly if not a high priority with policy makers) will be addressed. As previously stated, the limitation is that adolescent health and development may be fragmented, not given enough resources, or not co-ordinated under one policy, one directorate, and one plan of action.

Sri Lanka: Mainstreaming ADH into existing national policy

Sri Lanka has a National Health Policy (1996), and a National Policy on Population and Reproductive Health (1998). Sri Lanka does not have a national policy specifically on ADH and is planning on developing ADH Policy but does not have the possibility of doing so immediately. However, the National Policy on Population and Reproductive Health has a goal specifically on ADH and the Presidential Task Force for the National Health Policy includes Family and Adolescent Health—which demonstrates that adolescent health and development issues are mainstreamed into the existing policy environment.

Sri Lanka is in the process of developing specific ADH policy and can refer to the National Policy on Population and Reproductive Health as a framework for developing a National ADH Policy.

Mainstreaming adolescents and youth issues into National HIV/AIDS Strategies, Policies and Plans: Senegal, Burkina Faso and Cameroon

Senegal, a success story in the fight against HIV/AIDS, is also an example of how youth issues are integrated into National Plans to Fight HIV/AIDS. The HIV/AIDS National Plan serves as a policy in which adolescents and youth are recognized as key to the prevention of HIV/AIDS and are integrated into prevention strategies. The Policy calls for multisectoral collaboration with the Ministries of Youth, Education, Family and Labour as well as youth organizations. Activities include the development of 10 youth information centers, integration of STI/HIV/AIDS prevention through school health and nutrition programmes, and services for youth on issues related to reproductive health, with a particular emphasis on HIV/AIDS (Plan Strategique 2002-2006 de Lutte contre le SIDA).

Burkina Faso's National Multisectoral Plan to Combat STIs/AIDS includes IEC activities specifically targeted at youth, such as information counselling and STI screening at youth centres and support for IEC campaigns for youth in the regions. (Calvès, Policy Working Paper Series, No 8. 2002).

Cameroon's National Plan to Combat AIDS in Cameroon, elaborated in 1999 by the Ministry of Health recognizes youth as a specific population that requires attention to the achievement of its goals, and has a specific objective related to young people aged 15-24 years. (Calvès, Policy Working Paper Series, No 8. 2002).

Romania and Bulgaria: National Youth Policies developed as part of compliance with EU policy

The European Union (EU) and the Council of Europe (COE) have worked to strengthen cooperation with the countries of the SEE and established the Stability Pact in 1999, as an instrument to contribute to the stability and the development of civil society. A focus on youth, expressed through youth policies, are seen as key to achieving these development pre-requisites for membership in to the EU.

Romania has developed a Youth National Action Plan which was launched in Parliament in June 2001. **Bulgaria** developed a Youth charter and Action Plan in April 2001. Both policy documents address the issues of youth development and participation in civil, social, cultural, economic and political life. Links to heath are indirect or non existent. (Draft discussion paper version 15.04.2002 Conference on Youth in SEE: Policy for Participation and Empowerment 29-31,2002)

Option 3: **Formulate legislation related to adolescent health and development.** Programme managers and advocates of adolescent health typically work on formulating and shaping legislation favourable to adolescents. Although influencing policy is an activity that complements the formulation of national policy, some countries focus on adopting legislation, rather than develop national policy.

If a policy environment exists where there is either an explicit policy addressing adolescent health and development, then a country may opt to develop, shape and influence legislation favourable to adolescents.

Colombia – National Youth Law but no overarching Adolescent National Policy

Colombia developed a Youth Law in lieu of a national policy for youth development. The Colombia Youth Law was approved by the full house of the Senate and final approval through a deputy chamber. The Youth Law was enacted in July 1997. The law outlines a promotional approach to youth development and addresses the need to formulate youth policies and introduces a national system for youth with decentralized structures and funding sources. Commonly a law is viewed as an instrument to support a policy and in the absence of a policy framework (Russell 2001) p. 12 Colombia now awaits a national youth policy (p. 16 Russell).

Dominican Republic - Program –Policy – Law

The Dominican Republic's Ministry of Health established its national adolescent health program in the early 90's. The Ministry's adolescent health program was key to established an intersectoral committee on young people which sprung from a health and development framework—that tracking youth health problems could not be done in isolation but through multisectoral partnerships. The role of the youth intersectoral committee (Comite Intersectorial en pro de una Political Integral de Adolescencia y Juventud) was to develop a National Youth Policy. The Dominican Republic officially approved its National Youth Policy in January 1998. The policy is approximately 80 pages and test is divided into three sections. Given the strong role of the Ministry of Health in initiating the Youth Policy, health is one of the main sections of the policy, along with education, labour and job training, social participation, culture, legislation and sports and recreation. Each priority area includes objectives and an implementing institution assigned. Upon publication of the National Policy on Adolescence and Youth, the intersectoral committee starting drafting a law which was submitted to Congress in October 1999. The Youth Law was passed in the House of Representatives and was signed into law by the President in August 2000. The Youth Law institutionalizes the DGPG Directorate to Promote Youth as a permanent affiliation in the executive structure of the government as part of the Department of Youth. The Law also allocates 1% of the national budget and 4% of the municipal budget to implementing the law. (Rosen, 2000; Russell and Solorzano, 2001)

2.2 Setting priorities, goals and objectives

At this point, all the components necessary for setting the policy priorities, goals and objectives are complete. However, setting the priorities must be done with stakeholder consensus and each stakeholder may have different perceptions on what the priorities should be. Priorities should be set based on the gaps in existing policies and legislation, programming and the needs identified by young people. Priorities also need to be set according to what is most important, as judged by the situation of adolescents, the political support and commitment, what is feasible given the resources, (human and financial) and the strengths and weaknesses of existing programs and services. As this is meant to be a national policy to be adopted by the government, priorities should correspond to national priorities with respect to health, adolescents and their development.

Goal of a policy is to promote and protect the needs and rights of adolescents to access information, basic life skills, comprehensive health services, and safe and supportive environments --*WHO Western Pacific Region*

2.2.1 Policy Content: What should be in a policy document

The comprehensive list of areas that affect adolescent health and development were highlighted under the situation analysis section. The conceptual framework presented at the beginning of the document highlights the interrelation of all these issues to adolescent well being and development. There are several documents that can describe what issues affect adolescents and their links to their health and development. However, a few important points are highlighted.

- Age categories or definitions of young people differ among countries, therefore content may differ among countries.
- Recognize that adolescents are not a homogeneous group. They are married, mother and fathers, sexually active, sexually inexperienced, soldiers, labourers, indigenous, urban, orphans, etc…
- The areas highlighted as important for the situation analysis are obviously key to the programmatic content. The important thing is to prioritize areas based on the situation analysis, feasibility of government entities and partners to actually implement given financial and human resources.

Key resources:

1. WHO Technical Report Series. Programming for Adolescent Health and Development.
2. WHO. Growing in Confidence: Programming for adolescent health and development. Lessons from Eight Countries.
3. WHO/UNFPA/UNICEF. Action for Adolescent Health: Towards a Common Agenda. Recommendations from a Joint Study Group.
4. WHO. HIV and Young People: WHO Takes Action. October 2002.
5. WHO. Working with Boys. Programme Experiences: Consolidated findings from regional surveys in Africa, the Americas, Eastern Mediterranean, South-East Asia, and Western Pacific, 2000
6. WHO. Should Adolescents be Targeted for Nutrition in Developing Countries. To address which problems, and how?
7. WHO. Global consultation on Adolescent Friendly Health Services. A consensus statement. Geneva 7-9 March 2001.
8. PAHO/WHO. Mangrulkar, L., Whitman, CV., Posner, M. Life Skills Approach to Child and Adolescent Heatlhy Human Development.

Countries in the Region of the Americas have decided to take on a adolescent development approach, with health taking on an important role in broader adolescent development policies. Many of the countries in the Americas with national policy for adolescents are in fact National Youth Policies, which focus on adolescent development. The following table is a model for the Region of the Americas of what should be included in a Comprehensive Youth Policy.

Components of a Comprehensive Youth Policy [9] Objectives by Sector

Health

- Promote "youth friendly" services that empower adolescents to exercise their right to health services and to protect their own health.
- Support health information and education that promotes positive health and social behaviors, safety and non-violence
- Integrate health services including reproductive health, psycho-social support, and health promotion and prevention to maximize resources and improve access
- Support research to improve physical and psychological health of adolescents
- Support water sanitation and healthy household environment
- Support capacity building for professionals working with adolescents

Education

- Promote adolescent's's right to formal education, set compulsory secondary education of high quality and limit drop outs
- Include formal health promotion education, including reproduction, interpersonal skills, diet/hygiene/exercise, and other social values in secondary curriculum
- Provide equal opportunity to secondary education for the mentally and physically disabled
- Embody education, including health education and vocational training, into obligatory military or national corps service
- Support the promotion of peer support groups

Economic: Labour and Social Security

- Encourage vocational training and apprenticeship that enhances adolescent development but does not interfere with schooling, recreation, and rest
- Protect working young people by setting occupational health requirements and minimum age, wage, and hours of work standards.
- Promote savings, investment, and employment
- Provide social support for the health and education of adolescents living in impoverished conditions

[9] Model taken from Rodriguez-Garcia, R. Russell, JS, Maddaleno, M., Kastrinakis, M. Pan American Health Organization. W.K. Kellogg Foundation. *The Legislative and Policy Environment for Adolescent Health in Latin America and the Caribbean*, Washington, DC, June 1999

Socio-Political

- Promote activities that encourage youth participation in self-governance and local leaders networks

Commerce and Industry

- Create job training programs to promote employment and income generation
- Restrict the distribution, advertisement, and sale of products that adversely affect the health of youth, including tobacco products, alcohol, illicit drugs, and firearms

Justice

- Enforce requirements for vehicular safety, including driving under the influence of drugs and alcohol, requiring safety belts, and provisions for legally driving a vehicle
- Support mental and physical rehabilitation and support services for youth involved in the judicial system

Sports and Recreation

- Support recreational activities for youth, opportunities for young people to excel in sports, and healthy physical environments

South Africa has a comprehensive health and development approach in their national policy which addresses adolescents and youth. The following tables highlights the objectives and strategies included in their policy[10].

Policy Guidelines for Adolescent and Youth Health

Guiding Concepts

Youth and adolescent development underlies the development of health problems
Problems have common roots and are interrelated
Youth and adolescence is a time of opportunity and risk
The social environment influences youth and adolescent behaviour
Not all youth and adolescents are equally vulnerable
Gender considerations are fundamental

General Strategies

Promoting a safe and supportive environment
Providing information
Building skills
Providing counselling
Improving health services

[10] Policy Guidelines for Adolescent and Youth Health. Draft 3 document. June 1999.

Intervention settings

Home
School
Health facility
Workplace
Street
Community organisation
Residential centre

Health priorities

Sexual and reproductive health
Mental health
Substance abuse
Intentional injuries
Unintentional injuries
Birth defects and inherited disorders
Nutrition
Oral health

PHASE 3: POLICY APPROVAL PROCESS

In order for the national policy to become officially recognized by the State, it needs to undergo an approval process. The approval process will vary by each country, but most countries[11] report that in order for a policy to become official, it first needs to be approved within the Ministries, then by the Cabinet or Prime Minister (through an approval by the various Ministries). It is best if the policy document is approved into an official document of the State, rather than the government, so as to sustain changes in government.

Many policies remain drafts, which partially due to the political and/or legal processes that are required for a policy to become official. Several countries such as Ghana, South Africa had drafts for many years although in practical terms the Policy document was considered approved by the stakeholder groups. As the policy documents need approval from stakeholder groups and the Cabinet, it often takes time for the document to make it through those political processes required for actual adoption.

Countries that have a Minister of Health or high level political leader that considers adolescents a priority tend to have the policy adopted at a faster pace than others. Therefore, advocacy, media and communication are key to the policy approval process in that it serves to make the general public and policy makers aware of the policy process and can help make the policy a priority for approval.

PHASE 4: MAKING THE POLICY OPERATIONAL

In order for the policy to be a practical dynamic document used by stakeholders, it needs to be operationalized through an implementation plan, such as a plan of action or work plan. If an implementation plan of some sort is not developed, the policy runs the risk of being a document of no relevance, not being consulted for programming and coordination on adolescent health and development issues.

[11] Fiji, Haiti, Ghana, Malaysia, South Africa

South Africa

South Africa recently launched its Adolescent and Youth Health and Development Policy. South Africa has a decentralized health system where the provinces have responsibility for implementing the health policy. The Ministry of Health is in the process of sensitizing the provincial health ministries on the policy and each province will then take on the responsibility of developing a work plan, budget and evaluation plan for the implementation of the policy.

Nigeria

Nigeria developed its National Adolescent Health Policy in 1995, which includes a multidisciplinary and multisectoral approach to adolescent health and development.
Prior to that Nigeria passed the National Health Policy and Strategy to Achieve Health for all Nigerians in 1988, which provides a framework for all persons living in Nigeria to have access to health care services. The Adolescent Health Policy was developed, recognizing that adolescence is a period of transition which needs specific attention with respect to health services, education and skills.

The Nigerian Adolescent Health Policy outlines a framework, goals and objectives for ADH. The policy calls for an "appropriate climate for policies and laws necessary for meeting adolescent health needs". It also assigns the roles and function of major partners, and calls for the "establishment of a National Programme on Adolescent Health to undertake direct service provision, basic and operational research, development and adoption of special methodologies, the systematic collection, analysis and dissemination of information relevant to the health of adolescents".

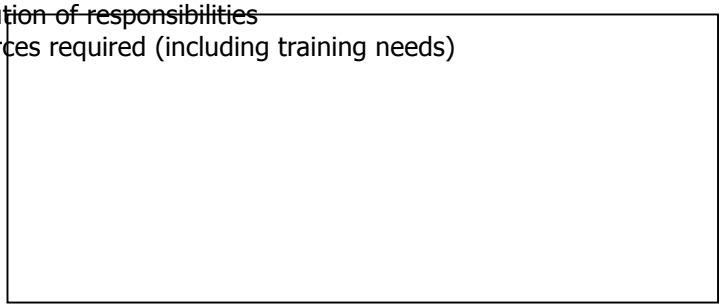
In order to implement the reproductive health aspects of the Policy, the Federal Ministry of Health, in collaboration partners, held a National Conference on Adolescent Reproductive Health in January 1999 to articulate a programme of action for operationalising the reproductive health component of the National Adolescent Health Policy. Following this Conference, Nigeria developed the National Strategic Framework for Adolescent Reproductive Health, to operationalize the reproductive health section of the ADH policy. (Federation Ministry of Health, National Strategic Framework for Adolescent Reproductive Health, Abuja, Nigeria 1999; National Adolescent Health Policy, 1995)

4.1 Implementation plan with budget

Even countries that develop National Strategy may require a more detailed plan for implementing the strategy, particularly for decentralization of the policy to the district and municipal levels. A few countries found that the policy document itself lacked the detail required for it to be a feasible at the operational level. It is important to take advantage of the momentum created by the development process and continue with the implementation plan. Applying such practical details such as a timeline, responsible agency, budget and human resource implications to the policy, can serve to make the policy a more realistic and feasible document to pass at higher political levels. Second, estimating costs for putting the policy into practice could provide donor agencies with a good justification for financing programs. Donors tend to appreciate well co-ordinated efforts among stakeholders (so as to reduce duplication) and strategically thought out (to contribute to sustainability of the program).

What to include in implementation plan

- ✓ Budget required and resources available
- ✓ Targets – what to achieve
- ✓ Plan for implementation at district, municipal levels with a distribution of responsibilities
- ✓ Human resources required (including training needs)
- ✓ Timeline



4.2 Monitoring and Evaluation

Monitoring and evaluation are important to tracking whether policy is being implemented and if goals and objectives are being achieved. It is important to ensure that policy goals and objectives are feasible. Mechanisms for monitoring and evaluation are needed at the start of policy implementation and indicators for policy implementation should be included in the implementation plan—as monitoring and evaluation of the policy are in fact achieved through programme indicators. It is particularly important because supporters of adolescent policy will require information about policy and programme results.

Key resources:

1. The WHO Programming for Adolescent Health and Development.
2. Monitoring and Evaluating Adolescent Reproductive Health Programs. Focus on Young Adults. Tool Series 5.

The involvement of young people in the **Dominican Republic** was a key to initiating and keeping the policy development process moving forward. When the government changed in the Dominican Republic, the youth groups that had participated in the process formed the main group to pressure to continue the process, *Rosen, 2000*

Part III: Issues in Implementing ADH Policy

Issues in Policy Development and Implementation: Keys to success, or limiting factors?

Political commitment: Political commitment is most frequently cited as a key element to the policy development and implementation. If the political climate is such that it is favourable to adolescents and youth, the policy development process is facilitated from policy formulation to official approval.

On the other hand, elections can cause changes in political leaders and priorities. Therefore, a policy or strategy, particularly one that remains in draft form, or does not pass some type of official State approval (versus government approval), runs the risk of being left aside and/or neglected. A policy that does not undergo the formal approval process by the State runs less risk of being neglected by a change in political leadership. Legislation is more sustainable and most enduring. Countries try to maintain political commitment through advocacy with political leaders of all factions in order to sustain a focus on adolescents.

The First Lady in ***Bolivia*** was closely tied to the policy process. When election time came Bolivia used a number of strategies so keep the initiative from dying. One of the strategies used requires that proponents of a adolescent policy ensure that a new administration continue the initiative. First the process was depoliticized by distancing the first lady's office from the day to day management of the initiative placing the responsibility within the bureaucracy of the Ministry of Planning. They drew on the technical expertise of the civil servants—those most likely to keep their jobs after a change in government. Proponents also laboriously built a coalition of influential adolescent serving groups from outside the government and elevated the role of young people. When the power shifted those groups had a solid stake in the policy's moving forward. Advocates also found an ally in the new vice minister overseeing adolescent issues and after the transfer of power she was approached by members of the adolescent coalition. She recognized the value of the work begun under the previous administration and accepted the offer to brief new political appointees and technical staff about the goals of the youth policy initiative. The vice minister later embraced the process and became the initiative champion and key sponsor within the new administration. (*Rosen, 2000*)

Leadership and ownership: Linked to political commitment are the issues of leadership and ownership, which countries also cite as being of importance to the policy development and implementation. It is important for a person or agency to take the lead in the process in order for it to move, but at the same time other stakeholders must feel ownership to the policy document. As this is a health and development policy, it is logical that the Ministry of Health play a leadership role, and the Ministry of Health has spearheaded the process in most countries. In countries with National Youth Policy, the Ministry of Youth is the leaders. The Dominican Republic established an independent

multisectoral commission responsible for the development process, with leadership and strong support from a the President and First Lady. It is important that the leader ensure stakeholder ownership, particularly for the implementation of the policy. This can be done by rotating the responsibility of hosting multisectoral meetings, and ensuring that each stakeholder has a role in the development and implementation process. The main function of leadership is to ensure that the process moves forward and most countries agree that it takes the leveraging of multiple stakeholders, co-ordination, strong political commitment and human and financial resources to make this happen.

One of the limitations of leadership is that is can often change during implementation. It is important to take into consideration that ministries can have different infrastructures, systems and varying levels of technical capacity to implement the policy. If a National Youth Policy is being implemented by the Ministry or Vice-Ministry of Youth, often a Ministry of Youth has less leverage within the cabinet than a Minister of Health, Finance or Economy. This has implications for human and financial resources as well as the ministry's potential to pass important legislation or policies related to adolescents.

Colombia established a Vice-Ministry of Youth under the Ministry of Education, which has no evident accountability for implementing the Youth Law. Since the induction of the Vice-Ministry in 1994, six vice ministers have led the institution and the technical personnel have been equally transitional. The reality of intersectoral collaboration is more complicated than the expected and tension within the ministry has arisen upon the realization that high levels of responsibility have been place on a very "young" vice minister. The Vice-Ministry of Youth is often marginalized and does not wield the same power as other ministries. Negotiating for youth within other sectors and attempting to co-ordinate priorities has been difficult for the Ministry of Education, a task that goes beyond the ministry's usual duties.

In the summer of 1999, it was announced that the restructuring of the government did not allow for more than one ministry appointment. Therefore, the future role and directions of the Vice-Ministry are not clear. (Russell, PAHO, 2001)

In **Haiti** the policy development initiative started within the Ministry of Public Health and Population. Although there was strong intersectoral participation the leadership of the committee and policy development responsibility was undertaken by the Ministry of Health. Therefore, other sectors may not have felt the same sense of ownership or dedication to the initiative. The MSPP in Haiti tried to prevent such a situation by rotating the responsibility of presiding over meetings (across the different sectors) however, in practice leadership did not extend beyond the MSPP. Although this was not an issue for developing a draft policy it could be an issue for the approval process and the operationalization of the policy particularly if resources are assigned to each sector for implementation. Therefore, there needs to be strong political commitment and leadership at the national level (perhaps through the First Lady or the Prime Minister's office) to ensure that the adolescent policy extends beyond the interests of one particular sector.

Intersectoral Co-ordination and Stakeholder involvement: Intersectoral collaboration and stakeholder involvement is instrumental to ensuring that the policy is relevant to stakeholder groups as well as ensuring their buy-in for implementation. "The legitimacy of the policy is often the result of how the policy came to be, not what is contained in the policy" (Russell/PAHO p.21). Often a stakeholder group that has been

Two key problems have been encountered in the operationalisation of policies: human resource and finance. This has resulted from various problems that are both process and technical in nature. Budgets for the implementation of policies are not developed and not considered in the annual budgeting process of the department – **Samoa**.

Policy development is a very political process and it is important that the lead agency understand the agendas of the various stakeholders and try and find a suitable political resolution to these sometimes competing agendas – *Jamaica*

left out can later place obstacles in passing the policy document, or will not be as enthusiastic to see it through. Assessments indicate the stresses of including so many players. These include issues of competing or varying priorities and the time involved to co-ordinate so many actors.

Another challenge of a multisectoral group is to keep the interaction and collaboration dynamic and redefine its role as needed. A task force or committee may be established for the purposes of policy development, however the co-ordination should continue beyond the policy development stage. It may however be useful to redefine the functions and members of the group once the policy is developed for other purposes, such as official adoption and implementation of the policy. According to the Dominican Republic, officials of the National Youth Office have gradually readjusted the composition of the committee and the authority of its members. During policy development, technical capacity was necessary with political support, and during implementation the committee required strong political presence, with adequate technical support (Rosen, 2000).

Financial Resources: A stable and guaranteed funding source should be stipulated and attached to the process and the policy implementation phase. The Dominican Republic's Youth Law was successful in allocating 1% of the national budget and 4% of the municipal budgets for adolescent health.

Leverage the resources of international donor agencies.
Countries cite financial resources as a key obstacle to implementation of the policy.

Decentralization of Policy: Decentralization is a key issue to the implementation of the policy. In many countries, the policy development process was initiated at the central level and in some cases, the district/department, municipal levels were not heavily integrated into the process. Although it can be logistically and administratively difficult to include all levels of the government, at the same time, the greater the representation of the various levels during the development process, the greater their motivation and sense of ownership to actually implement the policy.

The reality of health sector reform in many countries makes decentralization a priority and the inclusion of district, department, or municipal level partners is key.
Upon policy approval, a necessary next step is to sensitise or education the various levels within the ministries on the policy and its implications for implementation. Malaysia found the need to re-orient the health services to meet the needs of adolescents, some of which require structural changes to clinic space and lay out in

order to make services more adolescent friendly. Malaysia also cites the need for competency-based training in the many aspects of adolescent health.

The Tanzania strategy includes an implementation plan for the national, regional, district and community levels. Each of the levels are expected to spearhead the implementation of the strategy. For example, at the national level, a multisectoral task force will be founded that will play a liaison role with the regional level secretariat. The regional level does the same with the district level, and provides technical support for district level implementation.

In Malaysia, health workers were surveyed to assess their awareness and opinions on the policy. Of the 90 health workers who sent in responses 63 (73%) heard of the policy and 52 had seen it but 21 said they had not found it to be useful as it lack the details necessary for implementation and that it needed a plan of action or guidelines for it to be more useful. This suggests that dissemination of the policy was successful having reached the peripheral levels within the Ministry within a few months if its official launch. It also demonstrates that a policy document requires a plan of action to make it work at the operational level. – *Dr. Narimah Awin, Director, Family Health Development, Ministry of Health, Malaysia*

External Factors: Influence of external donors, regional development frameworks—such as Millennium Development Goals, poverty reduction strategies, ICPD, SSOC influence the motivation for policy development as well as the content. Those involved in the policy making process in several countries acknowledge of technical co-operation, in the form of financial resources and technical expertise.

Utilise outside experts on policy development carefully and sparingly. Focus on capacity building for country nationals by utilizing local expertise to prepare and develop policies with technical cooperation by outside experts. While it may take longer to develop a policy using this process, it [illegible] local stakeholders, [illegible] training and ultimately [illegible] sustainability of implementation. – *Samoa*

Timing*:* Experiences from countries indicate that the policy process can take time. The Dominican Republic created their Directorate to Promote Youth in 1985 but did not publicly presented its National Policy for Adolescents and Youth until 1998. South Africa and Ghana's policy remained in draft form for several years, although it was being implemented by the stakeholder groups prior to official approval.

The most crucial steps, which include approval, implementation and monitoring lie in the hands of the various Ministries and ultimately the Cabinet. It is important to not lose momentum and to recognize that the policy development process can take time.
As a result of the political approval process, many national policies remain in draft form. However, countries have indicated that the process of policy development in itself proved a useful exercise in co-ordination and developing joint priorities among the various sectors.

Concluding remarks and future directions: There is still little information available on the actual implementation of ADH policy and even less on the impact of policy on

adolescent health and development outcomes. Given the increasing number of countries that are embarking on the policy development process, the upcoming years will prove useful for following the progress of countries in these areas. Given that many ADH policies are developed through multisectoral collaboration, it will be important to look at country experiences in implementing policy across different sectors. It will be equally important to evaluate the extent to which policy leads to improved ADH programming and its impact on adolescent health and development outcomes.

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