



Reaching out:

A learning guide for health programming with adolescents

Supported by

AstraZeneca 
Young Health Programme
A global community investment initiative

 **JOHNS HOPKINS
BLOOMBERG**
SCHOOL of PUBLIC HEALTH



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Table of Contents

Introduction

What is this learning guide about?	6
Learning guide objectives	6
Who is this learning guide for?	6
What's in the guide, and how can I use it?	7
What is the Young Health Programme?	8
Why is health a human rights issue?	10
What is the 'demographic dividend'?	11
Which health issues are we talking about?	11

Section One - Core Principles for Adolescent Health Programming

Core Principle One - Taking a socio-ecological approach

What is a 'socio-ecological' approach?	13
My Life My Space: environments in which adolescents live	16
Additional resources on participatory research	18

Core Principle Two - Mainstreaming meaningful youth engagement

What is youth engagement?	19
What do we mean by 'child protection'?	21
Making youth engagement meaningful	22
A framework for meaningful child participation	23
How is youth engagement put into action?	24
Additional resources on youth engagement	25
Additional resources on child protection	25

Core Principle Three - Gender mainstreaming

Why is gender an issue for adolescent health?	26
How can we start to integrate gender into our health programmes?	27
How can gender roles, behaviours and expectations impact on sexual and reproductive health and well-being?	28
Why is gender important in comprehensive sexuality education?	29
Example: Brazil – Integrating gender transformation into the Young Health Programme	30
Additional resources on gender	32

Section Two - Adolescent Health Issue Snapshots

Snapshot One - Child marriage and adolescent pregnancy

What is child marriage?	34
What is the global picture for child marriage?	34
What is the global picture for adolescent pregnancy?	34
How are child marriage and adolescent pregnancy interlinked?	35
What are the human rights issues associated with child marriage?	36
International legislation on child marriage	36
What are the health consequences of child marriage and adolescent pregnancy?	36
Programme interventions to prevent child marriage and reduce adolescent pregnancies	38
Example: YHP in India integrating child marriage as a risk to health	39
Additional resources on child marriage and adolescent pregnancy	40

Snapshot Two - Harmful Practices based on tradition, culture, religion or superstition

What are Harmful Practices?	41
Example: YHP addressing initiation rites (<i>Chinamwali</i>) in Zambia	42
How can programmes work to change Harmful Practices?	42
Additional resources on Harmful Practices	44

Snapshot Three - Young people who use drugs

What is the global situation for drug use among adolescents?	45
What are the health risks associated with drug use?	45
What is harm reduction?	46
Why do some adolescents use drugs?	46
How can programmes respond to help adolescents who use drugs?	47
Example one: YHP in India improving adolescents' access to information on drugs	48
Example two: Specialist NGOs in partnership to improve access to services and support for young people who use drugs in Indonesia	48
Additional resources on young people and drug use	49

Snapshot Four - Mental health needs

What is mental health?	50
How do mental health problems affect adolescents?	50
How can programmes respond to adolescent mental health needs?	50
Example: mindyourmind empowering youth in Canada around their mental and emotional health needs	51
Additional resources on mental health	53

Acronyms:

AIDS – Acquired Immune Deficiency Syndrome
CCCD – Child-Centred Community Development
CEDAW – Convention on the Elimination of Discrimination against Women
CRC – Convention on the Rights of the Child
CSE – Comprehensive Sexuality Education
FGM/C – Female Genital Mutilation/Cutting
HIC – Health Information Centre
HIV – Human Immunodeficiency Virus
JHBSPPH – Johns Hopkins Bloomberg School of Public Health
IEC – Information, Education and Communication
LGBT – Lesbian, Gay, Bisexual and Transgender
LSD – Lysergic acid diethylamide
MDGs – Millennium Development Goals
NCDs – Non Communicable Diseases
NFHS – National Family Health Survey, India
NGO – Non-Government Organisation
STI – Sexually Transmitted Infection
SRHR – Sexual and Reproductive Health and Rights
UNFPA – United Nations Population Fund
UNICEF – United Nations International Children’s Emergency Fund
YHP – Young Health Programme
WAVE – Well Being of Adolescents in Vulnerable Environments
WHO – World Health Organisation

What is this learning guide about?

This guide has been developed using experiences emerging from the Young Health Programme (YHP), with a special focus on Plan International's programme learning.

This guide is not a step-by-step toolkit or a blueprint for health programming with adolescents. It aims to support reflection on programmatic practice, and to encourage the application of lessons learnt in future programme work.

Learning in Plan programmes is about asking critical questions, reflecting on what has worked well or less well, what needs strengthening, what needs changing and why. It is important to keep reflecting on experiences, trying out new approaches, and building on lessons learned to improve programme interventions to support the realisation of adolescents' health rights. The lessons and approaches described here can be adapted and modified to apply to any situation. Plan's own learning on adolescent health continues to evolve. In a complex and rapidly changing development environment, we need to be adaptive and agile.

The guide also provides references for further resources to support this learning process.

Learning guide objectives

The resource aims to:

- » share an overview of the Young Health Programme's key approaches and experiences from current programmes
- » support learning for NGOs on gender-sensitive adolescent health programmes in economically-distressed and remote communities, with examples of practical applications, concepts and approaches.

Who is this learning guide for?

This learning guide has been specifically designed for programme staff working with adolescent girls and boys, programme managers, coordinators and advisors in NGOs implementing health (particularly sexual and reproductive health and rights) programmes. We want this guide to be useful for a variety of NGOs, not just Plan. However, please note that we primarily work with adolescent girls and boys in economically distressed and remote environments in low- and middle-income countries.

Readers will likely already have some experience implementing health programmes with young people, and we hope that this guide will support reflection and learning on those experiences.

What's in the guide, and how can I use it?

Section one:

Core principles for adolescent health programmes: taking a socio-ecological approach, mainstreaming meaningful youth engagement, and gender mainstreaming. This section articulates the core guiding principles that frame PlanUK's approach to effective and relevant adolescent health programming.

Section Two:

Adolescent health issues – snapshots (child marriage and adolescent pregnancy, Harmful Practices, young people who use drugs, mental health). As described on pages 9-12, these are some of the most crucial health issues facing adolescents today. These issues demand our attention because they are too often neglected and ignored for being too controversial or too sensitive.

At the beginning of each section are some learning objectives that the rest of the section focuses on. There is an introduction to the topic which provides the reader with key background information and context.

Each section ends with some points for reflection which provides an opportunity for the reader to reflect on what they have learnt, and additional resources for further reading. The guide aims to give an overview of some key issues, with more depth on particular questions. However, it is expected that readers would need to do some additional reading to develop more in-depth knowledge. We have provided a list of further reading after each section that readers may wish to consult.

The guide should support readers to design new programme strategies, and to reflect on their current health programmes and enhance key components of those.



Photo: Paolo Black for the Young Health Programme

What is the Young Health Programme?

The Young Health Programme (YHP) was launched in 2011 to help young people in need around the world to deal with the health issues they face so they can improve their chances of living a better life. The YHP is a global partnership between AstraZeneca, Johns Hopkins Bloomberg School of Public Health (JHBSPH) and Plan International. The programme works both globally and locally with an integrated approach that supports on the ground local community programmes and also provides a global research and advocacy platform.

Through research led by JHBSPH, the programme aims to build an understanding of the health needs of the most disadvantaged youth across the world. The key study is WAVE (Well-being of Adolescents in Vulnerable Environments) which aims to build a unique understanding of the health needs of adolescents and explore the barriers preventing access to health services and information. The research is being carried out in five cities: Baltimore, USA; Ibadan, Nigeria; Johannesburg, South Africa; New Delhi, India; and Shanghai, China. The site in Ibadan is funded by the Bill and Melinda Gates Foundation, and the other sites are funded by the YHP.

On the ground, the programme works across 18 countries with 22 local partners (December 2013)¹, bringing together the expertise and innovative thinking needed to make a difference. YHP partners are youth experts globally who ensure that the programmes meet the needs of youth, and - in many countries - the programmes are developed in consultation with youth advisors. By 2015, it will reach 500,000 young people between the ages of 10 and 24 directly and will touch an additional 500,000 lives indirectly. The programme adopts strategies that:

- » give adolescent girls and boys a stronger voice to ensure that health policies and interventions by duty bearers address their needs;
- » take a holistic approach to adolescent health, with adolescents at the centre;
- » focus on the importance of health promotion and disease prevention when approaching adolescent health issues;
- » ensure adolescents have greater prominence in future global health goals and programming².

As part of the YHP, a multi-year community programme (2011-2015) is currently being implemented by Plan UK in partnership with Plan country offices and local partner organisations in Brazil (Maranhao state), India (Delhi) and Zambia (Chadiza district in Eastern Province). The programme is focusing on empowering adolescent girls and boys to practice healthy behaviours and to promote gender equality: increasing public health service uptake by adolescents; strengthening health service delivery to be more 'youth-friendly'; and working with

¹ For detail on each programme, please see <http://www.younghealthprogrammeyhp.com/country-programmes/>.

² For more information on the YHP see <http://www.younghealthprogrammeyhp.com/improving-adolescent-health>.

decision-makers to contribute to policies that are more responsive to the health needs of adolescents.

This learning resource is primarily built on experiences and examples from Plan UK's implementation of the Young Health Programme.

Adolescent health – Why is health for adolescents an issue?

Adolescent girls and boys aged 10-19 years are often thought of as a healthy group. As a result they have been overlooked in many health policy frameworks, national health strategies and programmes. However, many adolescents do not enjoy a “state of complete physical, mental and social well-being”³, and a significant number of adolescents die prematurely due to ill health, predominantly in low-income and middle-income countries. Adolescent health is vital to the achievement of the health Millennium Development Goals (4,5,6), as well as being a key contributor to all the other MDGs. As insufficient progress has been made to address adolescent health rights under this framework, these issues need increased attention within the post-2015 development framework. The next development agenda needs to address the structural causes of inequality by prioritising marginalised and excluded adolescents, recognising the agency and capacities of adolescents, and responding to their unique needs and vulnerabilities.

As adolescent girls and boys transition from childhood to adulthood, major shifts in health are taking place. Reaching reproductive and physical maturity rapidly changes the health profile of an adolescent girl or boy. Currently, younger adolescents in particular are overlooked (as country-level Demographic Health Surveys have only collected data on young people aged 15 and above), and we don't know enough about reaching girls and boys with the right information and support before they need to navigate the many challenges of adolescence.

In 2004, almost two-thirds of the 2.6 million deaths among youth aged 10-24 globally occurred in sub-Saharan Africa and South-East Asia.⁴ Leading causes of death were recorded as: road traffic accidents (14 per cent of male and 15 per cent of female deaths), maternal conditions (15 per cent of female deaths), violence (12 per cent of male deaths), and suicide (6 per cent of all deaths).

³ WHO definition of health - WHO (October 2006), *Constitution of the World Health Organisation*, Basic Documents, Forty-fifth edition, supplement.

⁴ Patton, G. C., Coffey, C., Sawyer, S. M., Viner, R. M., Haller, D. M., Bose, K., Vos, T., Ferguson, J. and Mathers, C. D. (2009) Global patterns of mortality in young people: a systematic analysis of population health data, *The Lancet*, 374: 881–92.

Key adolescent health facts⁵

- » More than 2.6 million young people aged 10-24 die each year, mostly due to preventable causes.
- » About 16 million girls aged 15-19 give birth every year. Complications related to pregnancy and childbirth are among the leading causes of death worldwide for this group.
- » Every year 7.3 million girls under 18 give birth, including two million girls 14 or younger, who suffer the gravest long-term health and social consequences from pregnancy, including high rates of maternal death and obstetric fistula.⁶
- » Young people aged 15-24 years old accounted for 40 per cent of all new HIV infections among adults in 2009. Young women are three times more likely to contract HIV than young men.
- » In any given year, about 20 per cent of adolescents will experience a mental health problem, most commonly depression or anxiety.
- » An estimated 150 million young people use tobacco.
- » Approximately 430 young people aged 10-24 die every day through interpersonal violence.

Why is health a human rights issue?

The World Health Organisation (WHO) states that everyone has a right to the “highest attainable standard of health”.⁷ The UN Convention on the Rights of the Child (CRC) is the most widely ratified human rights treaty across the world. It outlines the rights to which all children are entitled to enable them to survive and develop, and is framed by the principles of non-discrimination; the best interests of the child; the right to life, survival and development; and participation. Article 24 on health and health services affirms that: “Children have the right to the highest possible standard of health and access to health and medical services.” The right to health is universal, indivisible and inalienable. This includes timely and appropriate health care (available, accessible, acceptable, affordable, good quality) and the underlying determinants of health (such as adequate water, sanitation, nutrition, shelter).⁸

⁵ UNICEF (2011), *The state of the world's children 2011 – Adolescence: An age of opportunity* and WHO (2011) *Fact Sheet No 345* <http://www.who.int/mediacentre/factsheets/fs345/en/index.html>.

⁶ UNFPA (2013) *State of world population, Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy* <http://www.unfpa.org/public/home/news/pid/15373>.

⁷ WHO definition of health, WHO (October 2006), *Constitution of the World Health Organization, Basic Documents*, Forty-fifth edition, Supplement.

⁸ UN Committee on Economic, Social and Cultural Rights General Comment on the Right to Health, 2000.

Sexual and reproductive health rights are outlined in various international and regional treaties and declarations, however these rights are often neglected, particularly for adolescents. Although young people's sexual rights are different to and more complex than adults' sexual rights, all people, including adolescent boys and girls, have the right to make healthy, informed and positive choices related to sex, sexuality and reproduction.⁹ Health services must be available to all and cannot be withheld on the basis of criminalising or restrictive policies, for example on minimum age or requirements for spousal or parental consent.

What is the 'demographic dividend'?

Forty-three per cent of the seven billion people alive today are under 25, and this reaches as much as 60 per cent in some countries.¹⁰ Creating the so-called 'demographic dividend' means making the right investments in order to realise the human, social and economic potential of this generation. In some Asian and Latin American countries, rapid declines in fertility have increased the proportion of working-age people compared to dependent children. Accompanied by investments in health, education and new economic and governance policies, this has contributed to accelerated economic growth.¹¹ The unprecedented number of young people across the world entering adulthood and their reproductive years over the next 15 year period will result in a projected 40 per cent rise in demand for safe, effective, and affordable methods of contraceptives.¹² Enabling young people to make informed and autonomous decisions about their bodies and their health is vital to catalysing and benefiting from such demographic opportunities.

Which health issues are we talking about?

Plan International's YHP has taken a primary focus on **sexual and reproductive health and rights** (SRHR), according to the priority needs identified in the communities where we work. Whilst very focused objectives are important to achieve impact in this sensitive area of work, we also believe that there are many advantages to integrating our SRHR work with other health issues. Adolescents aren't only concerned with their SRHR; they view their health holistically and it is also connected with their environment. SRHR for adolescents can be a particularly sensitive topic, so working on other health issues can also provide an entry point to this more sensitive work.

⁹ CRC and its general comments: GC 24, 3&4; Convention on the Elimination of Discrimination against Women (CEDAW); The African Charter on the Rights and Welfare of the Child, Maputo Protocol International declarations – International Conference on Population and Development (ICPD) and Beijing platform.

¹⁰ UNFPA (2011) *State of world population* <http://www.unfpa.org/public/home/publications/pid/8726> Documents, Forty-fifth edition, Supplement.

¹¹ Population Reference Bureau, *The challenge ahead – initiating a demographic dividend*, accessed at <http://www.usaid.gov/sites/default/files/documents/1864/EN-HLMM-DD.pdf>.

¹² Accessed at <http://www.unfpa.org/rh/planning.htm>.

We also consider two of the other most sensitive health issues – issues where it can be equally hard to access accurate information and to develop programmatic responses due to high levels of stigma. These are **drug use** and **mental health**.

Tobacco use and harmful use of alcohol and other drugs are two of the most common behavioural risk factors for non-communicable diseases (the other two are unhealthy diet and physical inactivity). These behaviours are inter-linked and have also been associated with risky sexual behaviours (that link to unintended pregnancy and cause disease), and with behaviours that result in injury and violence. These inter-related risky behaviours are initiated during youth, and are fostered by surrounding social conditions and the legal and policy environment. According to WHO:

"Nearly two-thirds of premature deaths and one-third of the total disease burden in adults are associated with conditions or behaviours that began in their youth"¹³

Adolescence is a crucial period for intervention to ensure good health and well-being throughout the life-course and at all ages.

¹³ WHO (2011) Fact Sheet No 345. <http://www.who.int/mediacentre/factsheets/fs345/en/>.

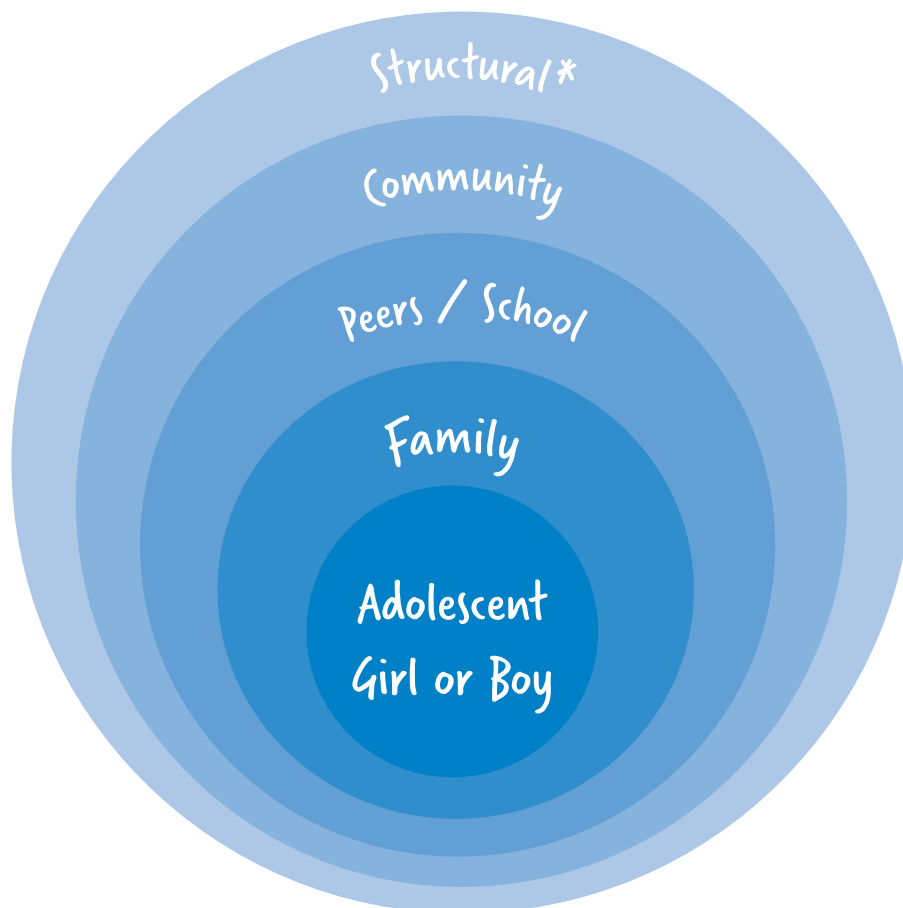
Core Principle one – Socio-ecological approach to adolescent health

Learning outcomes:

1. To understand 'socio-ecological' approaches
2. To understand how the lived environment impacts on adolescent health

What is a 'socio-ecological' approach?

A 'socio-ecological' approach to adolescent health considers the complex relationships between multiple levels of influence on health outcomes.¹⁴



* This includes the national level, laws and policies.

¹⁴ Socio-ecological models have been developed and refined by sociologists, psychologists and other academics over recent decades and have been used widely in global development, including by the WHO. This definition is similar to that shared in *Motherhood in childhood: Facing the challenge of adolescent pregnancy*, 2013. State of world population <http://www.unfpa.org/public/home/news/pid/15373>.

‘Child-centred community development’ (CCCD) is Plan International’s rights-based approach to empowering children and communities as leading actors in their own development. Although the term CCCD implies a focus on the community, the approach incorporates an understanding that meaningful changes in the lives of children require social, political, economic and cultural changes at many levels, transcending community and even national boundaries.

The CCCD focus on the structural causes of child poverty, gaps and violations of child rights requires a strategy with a long horizon. The expected outcomes in terms of changes in policy, political will, public attitudes and systemic changes in service delivery require a long and steady engagement. At the same time, the immediate manifestations of poverty and violations of child rights cannot be ignored and there is a pressing need to respond. Programmes have to be pursued on multiple levels with timeframes that are appropriate to the desired result.¹⁵

For too long, adolescent health programmes have over-used strategies which focus interventions narrowly at girls and boys. There needs to be a transformative shift towards broad-based approaches that build adolescents’ social assets and human capital, and focus on their agency to take decisions about their own lives. Meaningful youth engagement is essential at every step of Plan’s work (see Core Principle Two).

Influence from every level can impact on an individual adolescent’s health outcomes – for example, exposure to violence at home may breed violent behaviour within the adolescent, lack of access to a basic education means that adolescents may not be taught about how to protect their own health, and national laws can prevent adolescents from accessing contraception.

NGOs can use this socio-ecological model to support the development of a situational analysis, and to explore the full range of complex drivers affecting adolescent health. Programme interventions may not necessarily target every level. Depending on the local context, NGO experience, and opportunities available, programme interventions can be planned according to where they can achieve relevant and effective impact. Interventions can include a combination of: capacity building, information and education, access to services, and advocacy, and social accountability approaches. Our Snapshots of different adolescent health issues in Section Two of the guide will highlight examples of interventions operating at different levels.

¹⁵ Zuurmond, I. (ed.) (2010) *Promoting child rights to end child poverty*. Plan International, Woking, UK.



A socio-ecological approach is a rights-based approach – moving beyond addressing the needs and responding to the health problems of adolescents, to addressing the causes and structural drivers to reduce the health problems experienced by adolescents, enabling them to enjoy full health and well-being.

We all have to forge partnerships and linkages to align our interventions, share results and maximise impact. Actors at all levels have distinct competencies and roles to play, and therefore working in coalitions and alliances is an absolute must.

My Life My Space: environments in which adolescents live

Quality research that explores different influences on health within an individual's environment is vital to inform effective and targeted programme interventions. Adolescents' environments play a key role in terms of the health choices they make. Therefore, we need to understand the different environments that adolescents live in, what adolescents think about them, and the associated risks and protective factors that they offer. This includes an understanding of who has an influence on them, what activities are they engaged in and what are their aspirations.

Example: The Well-being of Adolescents in Vulnerable Environments Study

The Well-being of Adolescents in Vulnerable Environments (WAVE) study being led by Johns Hopkins Bloomberg School of Public Health focuses on disadvantaged adolescents and their health in very economically distressed communities across the world (Baltimore, Ibadan, Johannesburg, New Delhi, Shanghai). Much research has been done on easier-to-reach adolescents through schools and traditional family units, but to date there is limited data available on adolescents who don't necessarily go to school or live in a typical home environment.

Transformations in the world, which include changes in the global economy, education, family formation, and technology, are altering societies in every region, and in turn, are reshaping the contexts of adolescents' lives. What is unknown is the extent to which these changes impact adolescents' health, and their ability to obtain the resources they need to maintain health.



Strategies for the study include:

Phase one

Qualitative examination of the perspectives of youth and knowledgeable adults on adolescent health and well-being (field period 2011 –12):

- » in-depth interviews with youth
- » key informant interviews with the providers and directors of organisations serving youth
- » photo-voice projects by youth to document community health issues
- » community mapping and focus groups.

Phase Two

Respondent Driven Sample Survey¹⁶ to test results and themes emerging from the qualitative phase (field period 2013). This method manages 'snowball recruitment' by giving each respondent a limited set of coupons for referrals to health services. It has been relatively untried with adolescents previously, and advantages include that it gathers information about respondents' networks, and helps to reach out to those adolescents who are unstably housed, or out-of-school.

Example findings from Phase one – what factors influence adolescent health?

In Johannesburg, violence and safety was the most prominent theme. Adolescents were concerned about the violence in their neighbourhood and girls in particular don't feel safe. Adolescents experienced shame and discrimination as a result of the associations with their neighbourhood. The external environment mirrored adolescents' own experiences of abandonment and neglect.

In Ibadan, the environment posed different opportunities and risks for girls and boys. Boys were more mobile than girls, although this was not viewed as a disadvantage because most adolescents felt that girls are more vulnerable physically, and so need to be protected.

In Shanghai, adolescent migrant workers don't perceive health problems or risks in their working or social environments, but fear discrimination at health service delivery points because of their migrant status.

The findings from the WAVE study can be used by programme administrators and officials to improve the accessibility and effectiveness of resources intended to improve the well-being of severely challenged adolescents. Phase Two findings will be launched in 2014. For more information on WAVE see www.jhsph.edu/research/centers-and-institutions/center-for-adolescent-health/az/index.html

¹⁶ Heckathorn, D. D. (1997) Respondent-driven sampling: A new approach to the study of hidden populations. *Social Problems*; 44(2):174-198.

Points for reflection

- » The environment where we live has a significant impact on how we see ourselves, and how we understand our health
- » Adolescents are not a homogenous group and within a single geographical community there can be a wide diversity of experience. Access to health must be available to all including young married women and girls, young people with disabilities, young sex workers, young people who use drugs, young people living with HIV, young Lesbian, Gay, Bisexual and Transgender (LGBT) persons, and those who are excluded due to ethnicity, religion or other socio-cultural attributes
- » It is essential to engage adolescents at all stages of research on adolescent health; adolescents are experts on understanding perspectives of their own health and well-being.

Additional resources on participatory research

Ansumana, R., Malanoski, A.P., et al. (2010) Enabling methods for community health mapping in developing countries. *International Journal of Health Geographics*, 9:56. <http://www.ij-healthgeographics.com/content/9/1/56>

Kaufman, L.R. (2011) Community youth mapping: A tool for youth participation and program design. Education Development Center, Inc. and USAID; November 2011. <http://www.equip123.net/docs/e3-CYM.pdf>

Save the Children (2004) So you want to involve children in research? Save the Children UK. http://www.savethechildren.org.uk/sites/default/files/docs/So_you_want_to_involve_children_in_research_SC_2004_1.pdf

Soleimanpour, S., Brindis, C., et al. (2008) Incorporating youth-led community participatory research into school health center programs and policies. *Public Health Rep.* 123(6): 709–716. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2556716/>

Suleiman, A. H., Soleimanpour, S., London, J. (2006) Youth action for health through youth-led research. The Haworth Press. <http://ucce.ucdavis.edu/files/filelibrary/5458/31380.pdf>

UNICEF (2011) Case study on youth participatory research on education quality in Central and Eastern Europe and the Commonwealth of Independent States: Innovative practices, lessons learned and recommendations. http://reliefweb.int/sites/reliefweb.int/files/resources/EEPCT_YouthParticipatoryResearchCaseStudy_Dec2011.pdf

WaterAid (2005) Community mapping: A tool for community organising. <http://www.wateraid.org/~media/Publications/community-mapping-programme-partner-guidelines.pdf>

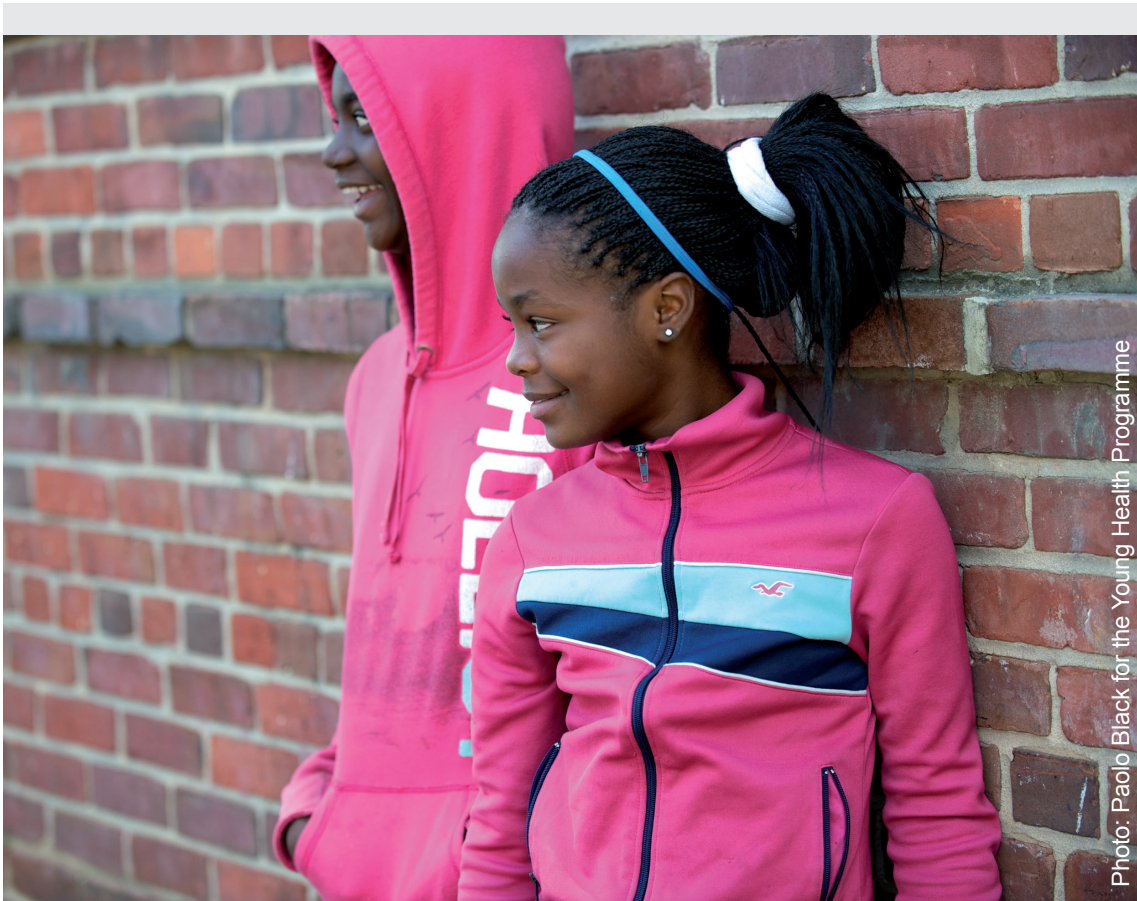
Core Principle Two – Mainstreaming meaningful youth engagement

Learning outcomes:

1. To be able to articulate benefits of youth engagement
2. To understand child protection as central to working with youth
3. To be able to ensure that youth engagement is meaningful with practical examples.

What is youth engagement?

“Youth engagement is the meaningful participation and sustained involvement of a young person in an activity, which has a focus outside of her or himself. Engagement also encourages youth to identify a personal connection internally, resulting in their own personal development and growth.”¹⁷



¹⁷ *Engaging youth in the creation of their own health states: Youth engagement toolkit*, **mindy-ourmind**, Young Health Programme partner, 2013. http://www.younghealthprogrammeyhp.com/_mshost2669695/content/pdf/youth_engagement_toolkit_final.pdf.

Why is youth engagement important?

- ✓ **Participation is a right guaranteed** in Article 12 of the UN Convention on the Rights of the Child. Plan firmly believes that children have the right to take part in the decisions that affect their lives, keeping in mind their evolving capacity to understand and to contribute. Participation should be free and meaningful and cannot be imposed. It should contribute towards results that are among the priorities of the participants themselves.¹⁸
- ✓ **Youth are the experts** on their experiences and the challenges of accessing health information, services and supplies.
- ✓ **Youth are important partners and credible advocates** for policy change. Youth can be effective ambassadors, garnering support for policy development and change, capturing the attention of political leaders and the media.
- ✓ **Youth bring creativity and innovation.** Youth naturally challenge the traditional attitudes that may restrict and limit how adults think and act. Youth can work together with adults to develop new ideas which can drive progress.
- ✓ **Youth bring diverse representation and provide generational insight.** Youth are not a homogenous group – they have a lot to offer, and can provide important insights into their differing needs. Engaging youth as advisors means that we can develop programmes that are more relevant and more effective.
- ✓ **Youth offer energy and vitality to the process,** encouraging staff motivation and helping to raise awareness of important issues.
- ✓ **Youth project a powerful and credible voice.** Youth have credibility with their peers, and can help to mobilise others. Their meaningful engagement can give a programme more legitimacy.

¹⁸ Zuurmond, I. (ed.) (2010) *Promoting child rights to end child poverty*. Plan International Woking, UK..



Each organisation needs to discuss and decide for themselves why youth engagement is important for them. In adolescent health programmes, youth engagement takes different forms. For example:

- » Adolescent girls and boys are trained and guided to act as community health researchers, identifying health issues and solutions using participatory methodologies.
- » Adolescent girls and boys are trained and supported to act as peer educators, to form youth groups and to become agents of change promoting health in their communities.
- » Adolescent girls and boys are empowered to claim their rights. The organisation can facilitate dialogue between adolescents (health service clients) and duty bearers (health service providers) in order to strengthen the local health sector response, and hold duty bearers to account.
- » Adolescent girls and boys are meaningfully involved in decision-making processes and advocacy platforms, and there is space for them to have a voice in decisions that affect their health.

"Being part of the Young Health Programme is a unique experience for me. When I became part of this programme my life changed completely because I learnt about my rights and the way I can request them in my personal life and also in social life. I feel myself to be an example to other adolescents." (18-year-old Peer Educator, YHP Brazil)

What do we mean by 'child protection'?

Child protection must be upheld throughout all areas of work with children, in line with the framework of the UN Convention of the Rights of the Child which states that:

- » children should be protected from any activities that could harm their development (Article 36).
- » all organisations concerned with children should work towards what is best for each child (Article 3).
- » governments should ensure that children are properly cared for, and protect them from mental and physical violence, abuse, exploitation and neglect by their parents, or anyone else who looks after them (Articles 19, 32-35).

Section One – Core Principles for Adolescent Health Programming



Plan International’s global child protection mission is “to create ‘child-safe’ environments – internally and externally – where children are respected, protected, empowered and active in their own protection, and where staff are skilled, confident, competent and well-supported in meeting their protection responsibilities through clear policies, procedures and good practice”.

- ✓ **Do no harm.** For programme initiatives engaging children and youth, it is important to seek full consent from parents/carers first. If the programme seeks to change social norms, particularly in relation to sensitive issues such as gender relations and sexual and reproductive health and rights, it is crucial to gain community support first so as to reduce resistance and avoid potential backlash.

Making youth engagement meaningful

Organisations that express their commitment to working with children and youth need to walk the talk!

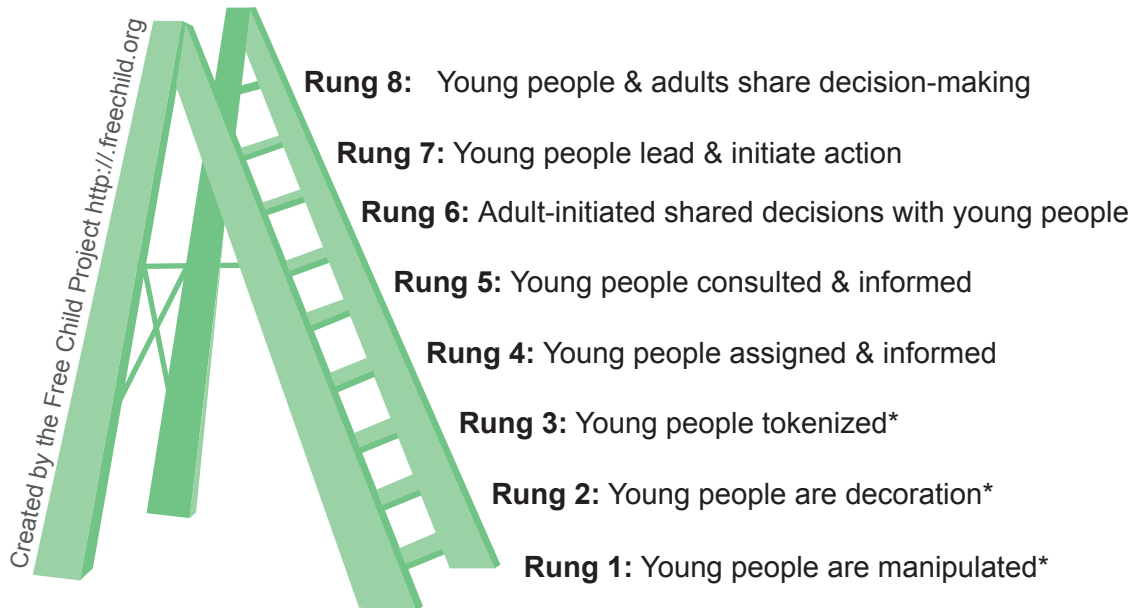
“At all steps in the programming cycle, Plan needs to ask itself how its processes and procedures can maximise the free and meaningful participation of children. One of the main objectives of participation is to strengthen children’s ability to speak out and to be heard. Participation thereby becomes a strategy with its own objective, more than just a methodology to develop quality programmes that respond to the needs and aspirations of children.”¹⁹

Plan UK has used the model overleaf, Roger Hart’s Ladder of Young People’s Participation, to analyse the current situation for youth engagement across the different programmes, and to support action planning in order to continually expand meaningful youth engagement. This model represents a hierarchy for different levels (illustrated as rungs on the ladder) of youth participation. As a starting point, ask the following questions:

- » What level are your youth engagement processes and activities at?
- » Can you think about how to move up the ladder, and stay up there?

¹⁹ Zuurmond, I. (ed.) (2010) *Promoting child rights to end child poverty*. Plan International Woking, UK.

Roger Hart's Ladder of Young People's Participation



* Hart explains that the last three rungs are *non-participation*.

Adapted from Hart, R (1992), *Children's Participation from Tokenism to Citizenship*, Florence: UNICEF: Innocenti Research Centre

A framework for meaningful child participation²⁰

1. **Transparent and informative** – Ensure that young people have timely, age and culturally appropriate information to ensure they are fully informed and 'information literate'.
2. **Voluntary and informed consent** – All participating children have voluntarily, and without coercion, agreed to be involved in the process and are fully informed and understand what the process involves.
3. **Respectful** – Children's time commitments are respected and accommodated. Ways of working and methods of involvement incorporate and build on local structures, knowledge and practice and take into account social, economic and cultural practices. Support is gained from key adults in children's lives to ensure wider encouragement and assistance for the participation of children.
4. **Relevant** – The issues on which children have the right to express their views must be of real relevance to their lives and enable them to draw on their knowledge, skills and abilities. In addition, space needs to be created to enable children to highlight and address the issues they themselves identify as relevant and important.

²⁰ The nine basic requirement key words were articulated in UN Committee on the Rights of the Child (CRC) 'General Comment No. 12 CRC (2009): The right of the child to be heard, CRC/C/GC/12, 20 July 2009. Available at: <http://www.refworld.org/docid/4ae562c52.html> Plan UK has used this framework to elaborate its best practice standards.

5. **Facilitated with child-friendly environments and working methods** – Environments and working methods should be adapted to children’s capacities. Adequate time and resources should be made available to ensure that children are adequately prepared and have the confidence and opportunity to contribute their views. Consideration needs to be given to the fact that children will need differing levels of support and forms of involvement according to their age and evolving capacities.
6. **Inclusive** – Participation must be inclusive, avoid existing patterns of discrimination, and encourage opportunities for marginalised children, including both girls and boys, to be involved.
7. **Supported by training for adults** – Adults need preparation, skills and support to facilitate children’s participation effectively, to provide them, for example, with skills in listening, working jointly with children and engaging children effectively in accordance with their evolving capacities. Children themselves can be involved as trainers and facilitators.
8. **Safe and sensitive to risk** – Analyse, understand and action mitigation where expression of views may involve risks. Adults have a responsibility towards the children with whom they work and must take every precaution to minimise the risk to children of violence, exploitation or any other negative consequence of their participation, both for them and for others associated with them (e.g. family members, students attending their school). Young people and their families need to be fully informed about any risks involved in the work they do.
9. **Accountable** – Children are entitled to be provided with clear feedback on how their participation has influenced any outcomes. Wherever appropriate, children should be given the opportunity to participate in follow-up processes or activities. Monitoring and evaluation of children’s participation needs to be undertaken, where possible, with children themselves.

How is youth engagement put into action?

- » **In Plan Brazil**, adolescents are engaged as YHP peer educators to raise awareness of key health issues, and to encourage attitude and behaviour change among their peers. The peer educators were presented with a standard methodology and curriculum to use for this purpose. The adolescents challenged this standard approach as they didn’t find it interesting enough. They brought creativity to the methodology, and added their own games and plays. This diversified approach has received positive feedback from all the participants.
- » **In Plan Zambia**, adolescents are engaged as peer counsellors at local health facilities as part of the YHP. Previously, adolescents reported finding these facilities unfriendly and intimidating, whereas now they can talk to ‘someone like them’, which has made the services feel more accessible.
- » **In Plan UK**, adolescents are engaged as part of the Youth Advisory Panel to the whole organisation. A young person also sits on the Board of Trustees, taking youth engagement to the very heart of our internal governance.

Points for reflection

- » Programmes which engage young people must be particularly sensitive to risk, considering the full potential implications of interventions to children and to those associated with them, and then develop appropriate mitigation actions or determine no-go situations in order to 'do no harm'.
- » Mapping youth engagement at every step of the programme cycle, and then monitoring implementation to understand whether or not youth inputs were given due consideration and adopted, and what the impact of that was, will enhance the quality of youth engagement.
- » Whilst many programmes are enhancing their work on building 'youth leadership', programmes where adults and youth truly share power and decision making are still rare.

Additional resources on youth engagement

CDC (2010) Best practices user guide: youth engagement – state and community Interventions. U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, Office on Smoking and Health. Atlanta, USA. http://www.cdc.gov/tobacco/stateandcommunity/bp_userguide_youth/pdfs/youth_engagement.pdf

FHI (2008) Youth participation guide: Assessment, planning and implementation. Family Health International. <http://www.unfpa.org/public/home/publications/pid/1325>

Plan UK (2009) Literature review: Youth participation in decision making processes. Plan UK, London. www.plan-uk.org/resources/documents/40221

YHP (2013) Engaging youth in the creation of their own health states: Youth engagement toolkit. **mindyourmind**, http://www.younghealthprogrammeyhp.com/_mshost2669695/content/pdf/youth_engagement_toolkit_final.pdf

Additional resources on child protection

UNICEF (2011) Child protection from violence, exploitation and abuse – Thematic report, 2011. http://www.unicef.org/Child_Protection_from_Violence_Exploitation_and_Abuse_2011.pdf

UNHCR (2012) A framework for the protection of children. UN High Commissioner for Refugees 26 June 2012. <http://www.refworld.org/docid/4fe875682.html>

WHO (2002) Broadening the horizon: Balancing protection and risk for adolescents. Department of Child and Adolescent Health and Development, Family and Community Health, World Health Organisation. http://apps.who.int/iris/bitstream/10665/67242/1/WHO_FCH_CAH_01.20.pdf

Wulczyn, F., Daro, D., Fluke, J., Feldman, S., Glodek, C., and Lifanda, K. (2010) Adapting a systems approach to child protection: key concepts and considerations. UNICEF, UNHCR, Save the Children [http://www.unicef.org/protection/Conceptual_Clarity_Paper_Oct_2010\(4\).pdf](http://www.unicef.org/protection/Conceptual_Clarity_Paper_Oct_2010(4).pdf)

Core Principle Three – Mainstreaming gender in adolescent health programmes

Learning outcomes:

1. To understand the difference between sex and gender
2. To understand how negative gender norms impact negatively on health issues affecting adolescent girls and boys
3. Following a gender analysis, to understand how to adapt programme interventions to respond to the differing needs of adolescent girls and boys (gender sensitive)
4. To understand how programmatic interventions such as comprehensive sexuality education seek to positively change power relationships between adolescent girls and boys (gender transformative).

Why is gender an issue for adolescent health?

As girls and boys experience puberty, negative gender roles and norms become more pronounced and this in turn has significant impacts on adolescent health. 'Sex' and 'gender' are different, highly inter-related concepts that both demand attention in adolescent health programming.

Sex: refers to the biological and physiological factors that define males and females. There are several examples of differences:

1. **Pregnancy** – women can become pregnant and men cannot. Pregnancy affects vulnerability to various health issues, including maternal mortality and morbidity, and some infectious diseases
2. **Anatomy** – women are biologically more susceptible to HIV infection than men, for example
3. **Immunity** – biological differences between women and men can affect vulnerability to infectious diseases.²¹

Gender: refers to the roles, behaviours and expectations that are socially constructed for men and women, girls and boys. These are not biologically determined. Gender roles are determined by that culture's gender norms and values and often give rise to gender inequalities – differences between men and women's access to and control over resources systematically empower one group (usually men and boys) to the detriment of the other (usually women and girls). Gender norms and values are not fixed. They evolve, they are learned, and are subject to change.

²¹ Wizemann and Pardue (eds.) (2001) *Exploring the biological contributions to human health. Does sex matter?* Committee on understanding the biology of sex and gender differentiation. Board on Health Sciences Policy, Institute of Medicine. National Academy Press, Washington DC.

Too often, gender is ignored by decision-makers and by programmers. Plan UK expects all its programmes to be gender-sensitive or gender-transformative as explained further below.

How can we start to integrate gender into our health programmes?

Gender sensitive programmes in Plan International mean the following²²:

- » Gender issues are clearly integrated throughout the programme documents.
- » A gender analysis of child rights has been integrated in the programme design.
- » Specific solutions to address the unique needs, interests and concerns of women and girls are included in the programme's objectives, outcomes and indicators.
- » Data is disaggregated by sex (male and female).
- » Specific human and financial resources are allocated to promote gender equality.
- » These programmes tend to improve the daily condition of women and girls (or their practical needs), but not their social position (how they are valued in society).

²² Plan International, 2013, Gender Equality Programme Criteria, *Planting Equality*.

Gender transformative programmes in Plan International mean the following²³:

- » An in-depth gender analysis of child rights has been integrated in the programme.
- » Objectives, outcomes and indicators explicitly aim to confront gender inequality, gender-based violence, gender roles and stereotypes, and to transform unequal power relations between men and women, boys and girls to become more equal.
- » The causes of inequality or discrimination are addressed head on in the programme (social norms, values), and all levels (including policy).
- » Data is disaggregated by sex (male and female).
- » Specific human and financial resources are allocated to address the root causes of gender inequality or injustices.
- » Programmes target girls, boys, women and men.
- » These programmes tend to improve the social position of women and girls (how they are valued in society as well as the realisation of their rights).

How can gender roles, behaviours and expectations impact on sexual and reproductive health and well-being?

Concepts of masculinity and femininity for boys and girls prescribe specific roles and status which are enforced by a society's institutions and practices. Social practices such as 'patriarchy' (which is strongly present in India and much of Asia and Africa) and 'machismo' culture (in Brazil and much of Latin America), are strong 'gender determined' practices. These are socially sanctioned behaviours where dominance is expected and condoned for men, whilst women are required to be docile and passive. This creates unequal power balances between boys and girls and also determines their unequal access to key resources including access to health information, commodities and services. Examples include the following:

- » A married woman contracts HIV because societal standards encourage her husband's sexual promiscuity, whilst inhibit her from negotiating condom use.
- » An adolescent boy dies from an overdose because he is trying to live up to societal pressures to be a bold 'risk-taker'.
- » An adolescent girl sustains several injuries from her boyfriend who beats her to prove his dominance and aggression.
- » A young adolescent girl develops obstetric fistula²⁴ after undergoing a prolonged labour at home because her family were too ashamed to take her to a health facility.

²³ Plan International, 2013, Gender Equality Programme Criteria, *Planting Equality*.

²⁴ The WHO estimates that more than two million young women live with untreated obstetric fistula – a hole in the birth canal – in Asia and sub-Saharan Africa, with 50,000-100,000 new cases each year. http://www.who.int/features/factfiles/obstetric_fistula/en/.

"The boys can tease the girls but it has never happened other way. In this way boys are totally safe. otherwise as far as I know, the girls are responsible for it because they only incite the boys to do such things...they give wrong indications to the boys. Because of these reasons boys look at them and do all these things and then they start to tease them. If the girls want, they can control themselves and prevent all these things to happen to them."
(16-year-old male, Delhi, WAVE)



Photo: Paolo Black for the Young Health Programme

"The boys get full freedom and they can go anywhere, they can roam and do anything they desire, but the girls are not given full freedom because if anything happens with them it will defame their whole family. That's why girls here have to live wisely. Parents restrict girls but the boys have full freedom because whatever they will do it will not defame them."
(17-year-old female, Delhi, WAVE)

Why is gender important in comprehensive sexuality education?²⁵

Young people who have developed egalitarian gender norms have better sexual health outcomes than their peers.

Research shows that young people who believe in 'traditional' or 'conservative' gender roles (for example, that boys should act tough or that females should be submissive to males) tend to have more sexual health problems. They are less likely to use condoms or contraceptives. They are more likely to be involved in an intimate relationship that is violent. Those in relationships with a high level of male control are more likely to be infected with HIV and to report unintended pregnancy. Similarly, intimate partner violence is associated with higher rates of unintended pregnancy, STIs, and HIV.²⁶

²⁵ Comprehensive Sexuality Education provides rights-based, gender-sensitive, culturally relevant and scientifically accurate information covering a range of issues including: gender, sexual health, HIV, sexuality, relationships, communication, intimate-partner violence, puberty, reproduction, contraception, and abortion.

²⁶ Population Council (2009) *It's all in one Curriculum. Vol 1: Guidelines for a unified approach to sexuality, gender, HIV and human rights education*. Population Council.

In the state of Minas Gerais in Brazil, the introduction of comprehensive sexuality education reduced risky sexual behaviours. The *Programa de Educação Afetivo-Sexual (PEAS): Um Novo Olhar* [the Programme for Sexual and Emotional Education: A New Perspective] operated in schools and emphasised accurate information on the risks and positive aspects of sexuality, gender equality and autonomy in decision making, among other aspects. The programme included high levels of youth engagement, outreach to parents and teacher training. An evaluation demonstrated that participants were twice as likely to use a condom consistently with a casual partner and 68 per cent more likely to have used modern contraception at last intercourse.²⁷

Schools are valid places to roll out comprehensive sexuality education in order to reach large numbers of girls and boys in a sustainable manner. However, these interventions will only work when support has also been gained from the local communities (including parents, teachers and local leaders) to value and support sex education and access to SRHR services. These programmes also need to reach beyond schools in order to reach the many boys and girls who are out-of-school and who are traditionally neglected or excluded by the existing infrastructure.

Example: Brazil – Integrating gender transformation into the Young Health Programme

Background: Brazil has one of the highest adolescent fertility rates in the world, with 71 pregnancies per 1,000 adolescents aged 15-19²⁸. In 2010, 19 per cent of births were mothers between 10-19 years of age²⁹. Rates have increased in recent years among girls aged 10-14. In the communities where the YHP works in Maranhão State, there is high incidence of HIV and STIs among female adolescents, increasing rates of adolescent fertility, high rates of unwanted pregnancy and unsafe abortions.

A survey on ‘Knowledge, attitudes and practices of the Brazilian population’, carried out by the Health Ministry in 2009, shows that though adolescents are the best informed age group, and the group that most often uses condoms in the first sexual experience (60.8 per cent), their behaviour changes when it comes to having sex with steady partners and the number drops to 30.7 per cent in the age range between 15-24. Research carried out by the YHP indicated that the reasons for teenage pregnancy are directly linked to underlying negative gender norms and notions of ‘machismo’.

Condom use is quite frequent in ad hoc, or shorter relationships. However, in long, steady relationships (where pregnancy normally occurs), condoms are no longer used as a proof of trust and fidelity. This is due to the inability of girls to negotiate safe sex due to power relations between the sexes. Furthermore, it is

²⁷ Andrade, H.H., de Mello, M.B., Sousa, M. H., Makuch, M. Y., Bertoni, N., Faúndes, A. (2009) Changes in sexual behavior following a sex education program in Brazilian public schools. *Cadernos de Saúde Pública*. 25(5):1168–1176.

²⁸ UNICEF, Brazil, 2010.

²⁹ Source: MS/SVS/DASIS – Born Alive Information System – SINASC (Brazil Health Ministry, 2009).

also common for parents to raise their children in a very repressive way when it comes to sex, which disempowers and demotivates children, especially girls, from using contraceptives and condoms.

"I have even tried (taking contraceptive pills), but my mother didn't support me ... She thought I was too young." (Natasha, adolescent mother, 18 years old, São José do Ribamar)

Programme Response: The YHP is addressing this challenge of negative gender norms and health choices through a programme that seeks to raise awareness of gender roles and attitudes among adolescents and how this shapes the choices that they make. At the same time, the programme response works with local government, teachers, and parents to tackle gender roles and norms in the wider environment.

The programme has built the skills and capacities of a team of peer educators by providing intensive training specifically around the shaping of gender roles and identities. It is expected that these trained adolescents will promote positive changes within their own lives and communities in the present and the future. Adolescents were trained using the partner agency Promundo's Programme M for Girls and Programme H for boys training curriculum.³⁰

The training sessions included sessions on gender, identity, sexuality, sexual health, reproductive health and human rights and how these interplay to determine access and uptake of health information, services and commodities.

Programme H manual topics: Working with young men, gender identity, sexuality, reproductive health, fatherhood and caregiving, violence prevention, emotional health, drug use, and preventing and living with HIV and AIDS.

Programme M manual topics: Working with young women, gender identity, relationships, sexuality, reproductive health, motherhood and caregiving, drugs, work, and preventing and living with HIV and AIDS.

³⁰ H stands for 'Homem' ('man' in Portuguese) and M for 'Mulher' ('woman' in Portuguese).

Section One – Core Principles for Adolescent Health Programming

- » 150 female and 113 male peer educators were trained through a participative methodology which stimulated them to question and analyse their own experiences and beliefs that perpetuate power inequities within the family, community and society.
- » Sessions were held separately with boys and girls who were then brought together for reflections and discussions over the course of 12 months.
- » Peer educators then reached out to a wider audience of 17,376 young people through outreach activities from 2012-13.

At the same time, the YHP partnered with the local government to train teachers and community health agents (frontline health workers). As a result of this twin-track approach – which worked to empower girls and boys whilst also changing the environment around them – sex education is now being increasingly accepted and debated in the school environment. This topic was previously a taboo among teachers and parents – now many schools in this area are allowing sex education workshops to take place within school time. These workshops are led by the peer educators with support from the teachers. In addition, peer educators have reported their increased ability to support friends who need referrals to health and social services, and improved communications with their parents.

Points for reflection

- » Critical analysis and reflection on gender should be an integral part of education and curriculum for girls and boys in order to improve health.
- » Programme research should explore how gender roles impact on adolescents' access to health information, commodities, services and health outcomes.
- » Witnessing positive changes in gender roles and social norms may not happen in the lifetime of a donor-funded project, making monitoring, evaluation and learning difficult.

Additional resources on gender

IPPF (2010) IPPF framework for Comprehensive Sexuality Education. International Planned Parenthood Federation, London. <http://ippf.org/resource/IPPF-Framework-Comprehensive-Sexuality-Education>

PAHO (2013) Integration of gender and human rights in HIV and sexual and reproductive health. Training for health care providers: Facilitators' manual. Washington, DC www.paho.org/hq/index.php?option=com_docman&task

Promundo, Instituto PAPAI, Salud y Género and ECOS (2013) Program H|M|D: A toolkit for action/eEngaging youth to achieve gender equity. Promundo: Rio de Janeiro, Brazil and Washington, DC, USA. http://www.promundo.org.br/en/wp-content/uploads/2013/06/hmd_toolkit_final_web-1.pdf

Population Council (2009) It's all in one curriculum. Vol. 1: Guidelines for a unified approach to sexuality, gender, HIV and human rights education. http://www.popcouncil.org/publications/books/2010_ItsAllOne.asp

UNFPA (2010) Comprehensive Sexuality Education, advancing human rights, gender equality and i sexual and reproductive health. <http://www.unfpa.org/webdav/site/global/groups/youth/public/Comprehensive%20Sexuality%20Education%20Advancing%20Human%20Rights%20Gender%20Equality%20and%20Improved%20SRH-1.pdf>

WHO (2011) 'Young people's health as a whole-of-society response' series. <http://www.euro.who.int/en/what-we-do/health-topics/health-determinants/gender/publications/young-peoples-health-as-a-whole-of-society-response-series>

WHO (2013) Gender, women and health (Information Sheets on: blindness, health in disasters, mental health, road traffic accidents, tuberculosis, HIV, tobacco, aging, malaria). <http://www.who.int/gender/genderandhealth/en/>



Snapshot one – Child marriage and adolescent pregnancy

Learning outcomes:

1. To consider the linkages between child marriage and pregnancy
2. To understand the health risks associated with early pregnancy
3. To explore programmatic interventions to prevent child marriage and reduce early and unintended adolescent pregnancies.

What is child marriage?

Plan International defines child marriage as any marriage – whether under civil, religious or customary law, and with or without formal registration – where either one or both spouses are children under the age of 18. The minimum age of 18 is considered appropriate to ensure that children are able to give their free, full and informed consent to marriage, and have the necessary maturity – physical, emotional and psychological – to enter into marriage.³¹

What is the global picture for child marriage?

One in three girls in the developing world is married before her eighteenth birthday. If nothing is done to stop current trends, more than 140 million girls will be married as children in the decade leading up to 2020.³² Child marriage is most common in South Asia and West and Central Africa, where 46 per cent and 41 per cent of girls get married before they are 18, respectively.³³ 82 per cent of girls in Niger, 75 per cent in Bangladesh, 63 per cent in Nepal, 57 per cent in India and 50 per cent in Uganda marry before the age of 18.

What is the global picture for adolescent pregnancy?

About 16 million girls aged 15-19 years give birth every year – that is roughly 11 per cent of all births worldwide. 95 per cent of these births occur in developing countries. Around one in five young women in developing countries becomes pregnant before age 18, and girls under 15 account for two million of the 7.3 million births that occur to adolescent girls under 18 every year in developing countries.³⁴

Adolescent girls experience high levels of sexual violence and coercion, and are often unable to protect themselves against early or unintended pregnancy. An estimated 150 million girls under 18 experienced forced sexual intercourse or other forms of sexual violence in 2002, according to a key WHO study.

³¹ Plan International Submission on Child Marriage to UNOCHR, December 2013.

³² UNFPA (2012) *Marrying too young: End child, early and forced marriage*. United Nations Population Fund, New York. <http://www.unfpa.org/webdav/site/global/shared/documents/publications/2012/MarryingTooYoung.pdf>.

³³ Ibid.

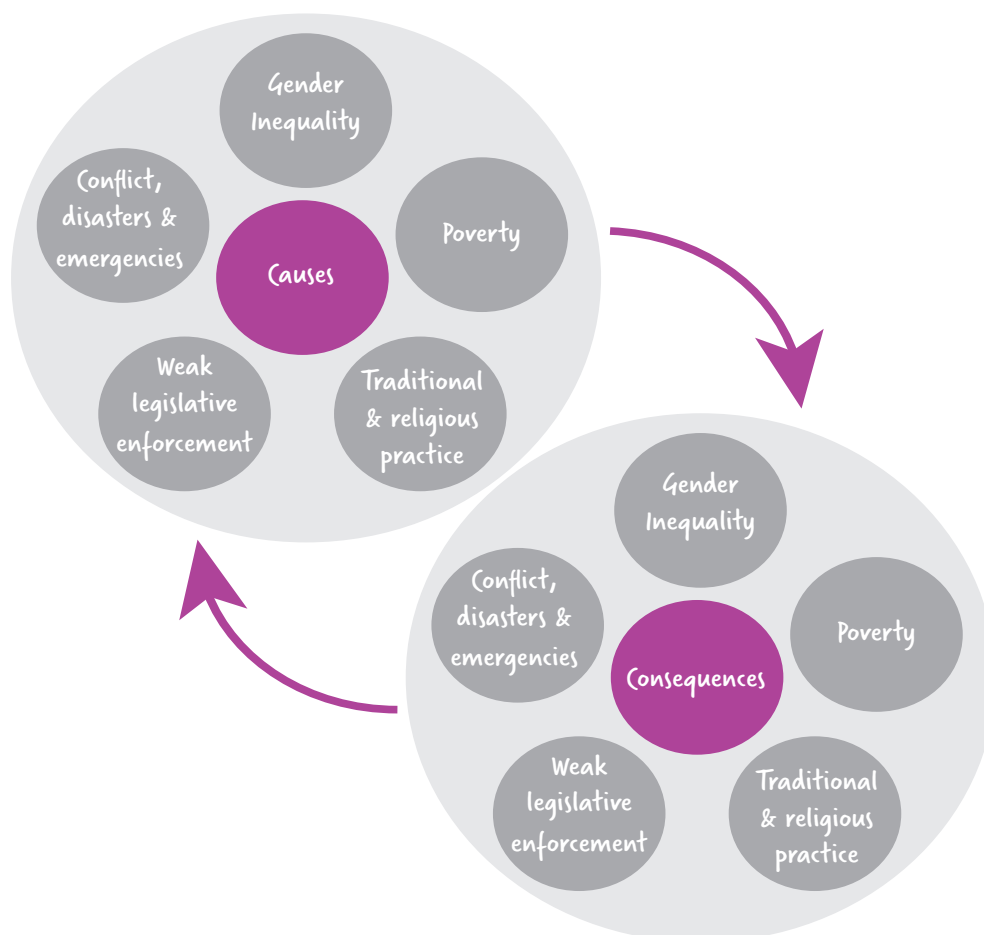
³⁴ Ibid.

How are child marriage and adolescent pregnancy interlinked?

An estimated 90 per cent of adolescents who give birth are married.³⁵ Close to 13.7 million 15-19 year old girls in the developing world give birth while married every year.³⁶ 80 per cent of married adolescent girls who want to delay or space pregnancy are not using any form of modern contraception.

The causes of child marriage are complex, interrelated and dependent on individual circumstances and context. The practice is driven by factors that include gender inequality, poverty, negative traditional or religious norms, weak enforcement of law, and the pressure caused by conflict and natural disasters.³⁷ Child marriage is also often seen by many communities as a protective factor against gender-based violence and pregnancy outside marriage. The causal relationships can be difficult to disentangle.

Cyclical relationship between causes and consequences: Child Marriage Trap



³⁵ Ibid.

³⁶ Ibid.

³⁷ *Breaking vows: Early and forced marriage and girls' education*. Plan UK (2011)...

What are the human rights issues associated with child marriage?

Child marriage is a serious violation of human rights. It infringes the rights and principles enshrined in the UN Convention on the Rights of the Child (CRC): the best interests of the child; non-discrimination; survival, health and development; protection from violence, abuse and exploitation; education; and full participation in family, cultural and social life – including participation in decisions that affect one's rights.³⁸

International legislation on child marriage

Article 16 (2) Convention on the Elimination of all forms of Discrimination against Women (CEDAW): The betrothal and marriage of a child shall have no legal effect, and all necessary action, including legislation, should be taken to specify a minimum age for marriage and to make the registration of marriages in an official registry compulsory.

In their general recommendations of 1994, the Convention considers that the minimum age of marriage should be 18 years. <http://www.un.org/womenwatch/daw/cedaw/text/econvention.htm#article16>

What are the health consequences of child marriage and adolescent pregnancy?

Complications in pregnancy and childbirth are the leading cause of mortality for girls aged 15-19 in low and middle-income countries.³⁹ About 70,000 adolescents in low and middle-income countries die annually of causes related to pregnancy and childbirth.⁴⁰

- » Health problems during pregnancy and labour are more likely if a girl becomes pregnant within two years of menarche (first period), or when her pelvis and birth canal are still growing.⁴¹ Physically immature first-time mothers are particularly **vulnerable to prolonged and obstructed labour**.
- » Pregnancy during those early years close to puberty increases the risk of **miscarriage, obstructed labour, postpartum haemorrhage, pregnancy-related hypertension and lifelong debilitating conditions such as obstetric fistula**.⁴²
- » Obstetric fistula (a hole in the birth canal) causes **incontinence** and, in most cases, results in a **stillbirth or the death of the baby** within the first week of life.⁴³

³⁸ Plan International submission on Child Marriage to UNOHCR, December 2013.

³⁹ UNFPA (2012) *Marrying too young: End child, early and forced marriage*. United Nations Population Fund, New York.

⁴⁰ UNICEF (2008) *Progress for children. A report card on maternal mortality*. United Nations Children's Fund, New York.

⁴¹ WHO (2004) *Adolescent pregnancy*. Department of Child and Adolescent Health and Development World Health Organization, Geneva.

⁴² The Office of Gordon and Sarah Brown (2012) *Out of wedlock, into school: Combating child, early and forced marriage through education*.

⁴³ UNFPA (2013) *Motherhood in childhood: Facing the challenge of adolescent pregnancy*.

- » Child marriage severely increases young girls' **vulnerability to HIV** as they are more likely to be forced or coerced into unprotected sex with their usually much older and more sexually experienced husbands.
- » Younger girls have softer vaginal membranes which are more prone to tear, especially on coercion, making them **more susceptible to STIs and HIV**. If untreated, STIs can cause **infertility, pelvic inflammatory disease, ectopic pregnancy, cancer, and debilitating pelvic pain** for women and girls. They may also lead to **low birth-weight babies, premature deliveries and life-long physical and neurological conditions** for children born to mothers living with STIs.⁴⁴
- » Data on abortions are scarce, however around 3.2 million **unsafe abortions** occur among adolescents aged 15-19 in developing countries each year⁴⁵ Adolescents are more likely than adults to experience complications such as **haemorrhage, septicæmia, internal organ damage, tetanus, sterility and death**.⁴⁶
- » **Stillbirths and newborn deaths** are 50 per cent higher among infants of adolescent mothers than among infants of mothers between the ages of 20 and 29.⁴⁷
- » Child marriage contributes to social isolation and disruption of networks that facilitate access to health information. Child marriage often leads to the isolation of young women which can have an impact on their **mental and emotional well-being**. Twice as many adolescent mothers develop **postpartum depression** as do women of childbearing age.⁴⁸



⁴⁴ UNFPA (2013) *Motherhood in childhood: Facing the challenge of adolescent pregnancy*.

⁴⁵ Shah and Ahman (2012) Unsafe abortion differentials in 2008 by age and developing country region: high burden among young women. *Reproductive health matters*. 20: 39, pp. 169-173. DOI: 10.1016/S0968-8080(12)39598-0).

⁴⁶ ISRRC (2002) *Children, youth and unsafe abortion*. International Sexual and Reproductive Rights Coalition for the United Nations General Assembly Special Session on Children. New York.

⁴⁷ WHO (May 2012) *Adolescent pregnancy*, Fact sheet N°364.

⁴⁸ [http://www.psychiatry.emory.edu/PROGRAMS/GADrug/Feature%20Articles/Mothers/Postpartum%20Depression%20\(mot 07\).pdf](http://www.psychiatry.emory.edu/PROGRAMS/GADrug/Feature%20Articles/Mothers/Postpartum%20Depression%20(mot%2007).pdf).

Programme interventions to prevent child marriage and reduce adolescent pregnancies

It is important to explore the causal factors and not just look at the health implications in order to bring about sustained change.

Intervention at individual level

- » Building girls' leadership skills through empowerment and capacity building, including through life skills education and peer educator training, to increase their active participation in society.
- » Comprehensive sexuality education in the school curriculum (see page 29), and access to accurate information on family planning, contraception, HIV testing, prevention and treatment for all boys and girls.
- » Programmes for young married and unmarried girls providing economic skills development with health information, counselling and referral services.
- » Home visits by health workers targeting married young girls (and couples) with information and referral services.
- » Those adolescents who do become pregnant should be provided with quality antenatal care and skilled birth attendance and post-natal support and follow up. Where permitted by law, those adolescents who opt to terminate their pregnancies should have access to safe abortion.

Intervention for parents and families

- » Reducing the social pressure that motivates families to practice child marriage by promoting attitude and behaviour change among men and women on negative gender norms and practices.
- » Community discussions on the harmful effects of child marriage on health with data from the community.

Intervention at peer level

- » Tailored peer education programmes for young girls and boys promoting more equitable gender norms, and highlighting the health implications of child marriage.

Intervention at community level

- » Working with community-based child protection mechanisms to intervene where girls are at risk of child marriage, and to respond to rights abuses among married girls and young women.
- » Supporting community leaders and community organisations to design, implement and support local advocacy activities that promote child rights and raise awareness about the negative effects of child marriage and underlying factors.
- » Support community opinion leaders to challenge social norms that make it difficult for adolescent girls to access health information and services.

Intervention at structural level:

- » Advocating for the formulation and enforcement of legal and public policy measures aimed at eliminating child marriage, including changing the legal age of marriage to 18 years for both girls and boys.
- » Advocating for the removal of legal barriers which prevent adolescents from accessing health services without parental or spousal consent.

Example: YHP in India integrating child marriage as a risk to health

Child marriage is a widespread and persistent problem facing the adolescent population in India, which has one of the highest rates of child marriage in the world. The latest National Family Health Survey (NFHS-3) data indicates that nearly half (45 per cent) of young married women in India ages 20-24 were married before the legal age of 18. Across India, the poorest and least educated girls experience the highest rates of marriage. Though legislation is in place, poor awareness and poor enforcement add to the problem. The NFHS-3 found that more than one in five women aged 20-24 had given birth before the age of 18 and one in eight women had three children before their 19th birthday (NFHS-3, 2007).

The YHP in India is responding to these challenges through strategies focused at the individual, peer, family and community level. For example: peer educators have been trained on the potential negative health consequences of adolescent pregnancy, and on the law on child marriage. In addition, discussion sessions have been arranged for parents to raise awareness of the potential negative health consequences of adolescent pregnancy, the law on child marriage, and how to communicate with their children about sex.

"I was married at the age of 15. However, now after attending the Plan Health Information Centre (HIC), I realise how important it is for my daughter (aged 15) to know her health needs and also earn a livelihood for herself as it will empower her. I want my daughter to be educated and work and not get married early. Both my husband and I are supportive and we encourage our daughter to come and learn from the Plan HIC."
(Parent reached by the YHP training)



Photo: Plan

Points for reflection

- » The complex relationship between negative gender norms, child marriage, adolescent pregnancy, and the multiple causal factors, demand careful study in the context where a programme is operating. Multiple actions at different levels will be necessary to overcome these problems, and change does not usually occur quickly.
- » The full potential negative health consequences of child marriage and adolescent marriage are not widely known. The myth of early marriage as a protective factor needs to be deconstructed.

Additional resources on child marriage and adolescent pregnancy

ICRW (2003) Too young to wed: The lives, rights and health of married girls. International Center for Research on Women, Washington DC.

<http://www.icrw.org/files/publications/Too-Young-to-Wed-the-Lives-Rights-and-Health-of-Young-Married-Girls.pdf>

ICRW (2006) Child marriage and health. Factsheet. International Center for Research on Women. Washington DC.

<http://www.icrw.org/files/images/Child-Marriage-Fact-Sheet-Health.pdf>

Plan International (2013) A girl's right to say no to marriage: Working to end child marriage and keep girls in school. <http://plan-international.org/girls/childmarriage-report/>

Plan UK (2011) Breaking vows: early and forced marriage and girls' education. <http://www.plan-uk.org/resources/documents/Breaking-Vows-Early-and-Forced-Marriage-and-Girls-Education>

Santhya, K.G., Jejeebhoy, S. J., and Ghosh, S. (2008) Early marriage and sexual and reproductive health risks: Experiences of young women and men in Andhra Pradesh and Madhya Pradesh, India. Population Council, New Delhi. http://www.popcouncil.org/pdfs/India_EarlyMarriageSRH.pdf

UNFPA (2013) Motherhood in childhood: Facing the challenge of adolescent pregnancy.

<https://www.unfpa.org/webdav/site/global/shared/swp2013/EN-SWOP2013-final.pdf>

Snapshot Two – Harmful Practices based on tradition, culture, religion or superstition

Learning outcomes:

1. To be able to explain what's included within Harmful Practices
2. To see how programme responses can change Harmful Practices

What are Harmful Practices?

Harmful Practices based on tradition, culture, religion or superstition are often perpetrated and actively condoned by a child's parents/carers and even the community at large.⁴⁹ Harmful Practices arise from discrimination against certain groups of people, such as women and girls, and violate the human rights of those affected. There is no universally accepted definition of these, and they are also referred to as Harmful Traditional Practices as they can be rooted in long-standing traditions, cultural and religious beliefs and social norms.⁵⁰ As there are many new and emerging Harmful Practices, many believe in extending the concept of 'Harmful Traditional Practices' to encompass these.

This extended definition could cover most of the human rights violations which occur within communities, however the spirit of this concept demands particular focus on those Harmful Practices which may have been neglected because of the strong acceptance and grounding in either tradition, culture, religion or superstition which makes violence against women and girls so difficult to challenge and eliminate.⁵¹ Health programmes must respect and work within the cultural values and traditions identified by a community, but it is important to realise that they cannot be continued at the cost of the right to health of the individual.⁵²

There are hundreds of different Harmful Practices including: honour killings, child marriage, bride price, dowry payments, son preference, sexual cleansing, widowhood- and puberty-related rituals, and female genital mutilation/cutting (FGM/C).

⁴⁹ International NGO Council on Violence against Children (2012) *Violating children's rights: Harmful Practices based on tradition, culture, religion or superstition*. International NGO Council on Violence against Children.

⁵⁰ Gender and Development Network (2013). *Harmful Traditional Practices: Your questions our answers*.

⁵¹ International NGO Council on Violence against Children (2012) *Violating children's rights: Harmful Practices based on tradition, culture, religion or superstition*. International NGO Council on Violence against Children.

⁵² Human Rights Watch (2005) *Dose of reality: Women's rights in the fight against HIV/AIDS*. Human Rights Watch, New York, USA.

How can programmes work to change Harmful Practices?

Too often, the harmful health effects of these traditions are not documented, explained or understood by the communities practising them. Health programmes must try to understand these rituals, gather evidence and focus on addressing these within their programmes at the individual, family, community and structural level. Here, we will review an example from the YHP, where the programme response seeks to address puberty-related rituals.

Example: YHP addressing initiation rites (*Chinamwali*) in Zambia

Tradition plays a central role in the lives of the people in Chadiza district. Two initiation ceremonies, *Chinamwali* (for girls) and *Gule wa mukulu* (for boys) are widespread and a key feature around which the adolescence phase revolves. *Chinamwali* is an initiation ceremony conducted largely for girls in the age group 10-15 although it can be done on girls up to 18 years of age.⁵³

The ceremony is seen as signalling to the community that the girl being initiated has reached puberty. It is also a ‘training programme’ where girls are provided with information about changes in their bodies and how they are supposed to take care of themselves from a hygiene point of view. The girls that have undergone *Chinamwali* are considered to be ‘adult women’ and accorded respect by the community, elevating them, in spite of their age, to a status accorded to older women.

The initiated girls are equally taught about sex and ‘how to satisfy a man sexually’, reinforcing limiting gender norms and increasing their health risks. In some instances girls may also be ‘tested’ (through sexual intercourse) to see whether they are able to put into practice what they have learnt. This has serious negative health implications as the ‘testers’ are older and sexually active and may be HIV positive or carrying other sexually transmitted infections (STIs). Coercing girls into sex in this manner also has implications for their mental health and well-being. *Chinamwali* has been identified as one of the major causes of early pregnancy and marriage, and of girls dropping out of school.⁵⁴

There is no specific law that governs initiation rites. On the contrary, initiation rites are generally celebrated and embraced by society with each ethnic group eager to show off its traditions.

⁵³ Matenga, C. and Tembo, R. (2008) referenced in YHP Country Research, Zambia, Plan Zambia, 2013.

⁵⁴ YHP Country Research, Plan Zambia, 2013.

The YHP in Zambia is addressing this difficult issue of initiation ceremonies and is working towards building awareness and sensitising the community on the harmful aspects of the tradition which negatively impact the health of young girls.

The strategies being used include the following:

Intervention at the peer level

- » Training peer educators on the health implications of initiation, early pregnancy, HIV and STI prevention, symptoms of STIs, HIV testing, contraception, condom use, negotiation skills, responsible behaviour.

Intervention at the community level

- » Drama performances to address very sensitive issues in a playful manner with the use of humour and exaggerated mime to defuse and 'open up' subjects that are typically considered taboo. The YHP has used community dramas to highlight various sensitive issues such as risky behaviour, multiple sexual partners and initiation ceremonies.
- » Working with community stakeholders to change the 'curriculum' that is taught to exclude harmful content.

For instance, one drama focusing on early pregnancy and cultural practices looked at the case of a man whose daughter was pregnant at 12 years old. As his friend consoled him, they discussed how the traditional ceremonies, which can be particularly damaging to young women, cause a problem when young people rapidly try out what they have been taught (how to have sex) without having adequate information or access to services and tools.

The father was reluctant to report the man who had impregnated his daughter to the police in case he had to pay back some of the cattle he had since received as payment. The daughter later died in childbirth. The father then realised the true loss of the situation and reported the incident to the police.

- » Mobilising and sensitising key stakeholders such as the village chief, district officials, school teachers, initiators (who conduct the ceremony) on keeping some useful components of initiation rites and doing away with the harmful ones in a phased manner. Plan Zambia uses its established relationship with the community to engage village leaders on this sensitive topic.
- » Radio programmes: the project is collaborating with the community radio station to record, produce and air 52 radio series. Key participants in the radio programme include youth, health service providers, traditional initiators and community leaders who discuss issues affecting youth in their communities, including initiation.

These interventions have led to some positive results such as more openness from the community to discuss and acknowledge the harmful effects of initiation on the health of adolescent girls. The village chief has also been open to discussing and reforming some harmful aspects of initiation.

Points for reflection

- » What are the roots of the harmful practices, and who is perpetuating them? How do they link to negative gender norms?
- » Given that traditions are deeply rooted in societies, are associated with community identities and are extremely sensitive, are programmes using existing entry points, influencers and established relationships to initiate social change?
- » Programmes need to document, disseminate and report Harmful Practices widely.

Additional resources on Harmful Practices:

OHCHR (1995) Fact sheet No.23: Harmful Traditional Practices affecting the health of women and children. UN Office of the High Commissioner for Human Rights (OHCHR). <http://www.ohchr.org/Documents/Publications/FactSheet23en.pdf>

Gender and Development Network (2013) Harmful Traditional Practices: Your questions our answers. Gender and Development Network, London. <http://www.gadnetwork.org.uk/storage/htp-report/GADN%20Harmful%20Traditional%20Practices.pdf>

International NGO Council on Violence against Children (2012) Violating children's rights: Harmful Practices based on tradition, culture, religion or superstition. http://srsg.violenceagainstchildren.org/sites/default/files/documents/docs/InCo_Report_15Oct.pdf



Snapshot Three – Young people who use drugs

Learning outcomes:

1. To understand why the use of tobacco, alcohol and other drugs is a health issue for adolescents
2. To be able to describe harm reduction approaches
3. To understand how the use of tobacco, alcohol and other drugs links to the environment, and to other behaviours that can be risky to adolescent health
4. To explore programme interventions to address harmful drug use

What is the global situation for drug use among adolescents?

It is difficult to develop a comprehensive picture of drug use among adolescents as many drugs are illegal and therefore people who use drugs are often criminalised and stigmatised. The vast majority of tobacco users worldwide began when they were adolescents. Today an estimated 150 million young people use tobacco. This number is increasing globally, particularly among young women. Harmful drinking among adolescents is an increasing concern in many countries. Alcohol use starts at a young age: 14 per cent of adolescent girls and 18 per cent of boys aged 13-15 years in low- and middle-income countries are reported to use alcohol.

What are the health risks associated with drug use?

Tobacco, alcohol and other drugs (including stimulants such as cocaine and amphetamine-type substances, depressants such as heroin and solvents, and hallucinogens such as cannabis and LSD) can all be potentially harmful to an adolescent's mental and physical health. Drugs affect individuals differently, and they may affect adolescents more than adults because their bodies and brains are still developing. Drug purity can vary greatly, and this is a significant issue. Drugs can occasionally cause very serious reactions, including in situations of drug overdose. Young people are more likely than adults to be poly-drug users, and it is also dangerous to take certain drugs together at the same time. Some drugs are highly addictive and once adolescents develop a habit, it can be hard to change.

Tobacco use can lead to chronic lung cancer and other pulmonary diseases. Half of tobacco users will die prematurely as a result of tobacco use (WHO). Alcohol use reduces self-control and increases risky behaviours. It is a primary cause of injuries (including those due to road traffic accidents), violence (especially domestic violence) and premature deaths. Adolescents who start to drink before they are 15 years old are five times more likely to develop

chronic alcohol dependence as adults than those who start drinking at age 19 or older.⁵⁵ Excessive alcohol consumption is associated with heart disease and some cancers. Alcohol use has been linked to early or unintended childbearing, multiple sexual partners, and earlier and unprotected sex. Alcohol use during pregnancy can also lead to foetal alcohol syndrome disorders.

What is harm reduction?

Harm reduction is described as a set of “policies, programmes and practices that aim primarily to reduce the adverse health, social and economic consequences of the use of legal and illegal psychoactive drugs without necessarily reducing drug consumption. Harm reduction benefits drug users, their families and the community”.⁵⁶ This accepts that people in every society use drugs, and therefore seeks to minimise the harms associated with this drug use (without requiring cessation of use). This is a compassionate response which seeks to provide care and support in a non-judgemental environment. Harm reduction interventions include support for safer injecting, pill testing, overdose prevention, and open and accurate information provision on how to reduce the harms associated with drug use.⁵⁷

Why do some adolescents use drugs?

Drug use may be affected by gender, age, ethnicity, and other socio-economic characteristics. Some adolescents may be more predisposed to use drugs than others, due to genetic or psychological characteristics. It may also be affected by social acceptance, and the drug use of an adolescent’s parents and friends. Other environmental factors which affect use include: availability, advertising and marketing practices, and legislation and public policies regarding certain drugs and the enforcement of those policies.

Select experiences and perceptions of drug use among young people, WAVE

“Floating Population who live and work in Shanghai mostly are under great working and life stresses/pressure. A lot of them choose smoking to relieve the stresses/pressure.”
(Male, 19 years old, 2011)

In Ibadan and Johannesburg, drug and alcohol consumption was said to be more of a problem for boys than girls, and was associated with violence.

⁵⁵ DeWit, D.J., Adlaf, E.M., Offord, D.R., and Ogborne, A.C. (2000) Age at first alcohol use: A risk factor for the development of alcohol disorders. *Am J Psychiatry*. 157, 745-750.

⁵⁶ IHRA (2012) *What is harm reduction? A position statement from the International Harm Reduction Association*. International Harm Reduction Association, London. http://www.ihra.net/Assets/2316/1/IHRA_HRStatement.pdf.

⁵⁷ Youth RISE, Harm Reduction and Young People briefing paper.

"No nothing has been done and if you can ask me to show you a place where you can get drugs I can take you there. The police know those places but aren't doing anything about that."
(male, 17 years old, Johannesburg, 2011)

How can programmes respond to help adolescents who use drugs?

As multiple factors influence drug use, a socio-ecological approach can be used to develop interventions to help adolescents who use drugs.

Intervention at individual level

- » Information, Education and Communication (IEC) materials on health promotion, drugs and harm reduction.
- » Brief interventions of advice and counselling (such as 'motivational interviews') when drug use is detected.
- » Age appropriate group-based behavioural therapy for those who are persistently aggressive or disruptive – and deemed at high risk of harmful drug use.

Intervention at work/carer level

- » Work with parents and carers to provide support and, where necessary, to refer them to other services.
- » Family-based programme of structured support to younger adolescents who are disadvantaged and deemed at high risk of harmful drug use.

Intervention at peer/school level

- » Peer education programmes on health promotion, drugs and harm reduction.
- » Programmes within schools on adolescent life skills and health promotion.

Intervention at community level

- » Work with the community (street plays, drama, talks) to promote support services and reduce stigma towards young people who use drugs.

Intervention at structural level

- » Advocating for a ban on tobacco advertising, raising the prices of tobacco products and laws prohibiting smoking in public places. All these measures are known to reduce the number of people who start using tobacco products. They also lower the amount of tobacco consumed by smokers and increase the numbers of young people who quit smoking.
- » Advocating for a ban on alcohol advertising and regulating access to it are effective strategies to reduce alcohol use by young people.

Example 1: YHP in India improving adolescents' access to information on drugs

The communities where the YHP is being implemented in India are in the National Capital Region of Delhi. These are resettlement colonies (formerly slums) and comprise mostly of migrants from other states. The communities are a product of urbanisation and of the massive economic growth that India is going through. However, these communities exist on the fringes of that urbanisation and have benefited little from the economic growth. The communities are marked by congested living conditions, lack of safe drinking water and of sanitation and waste disposal services. Violence is common and adolescents have few recreational activities. Many adolescents try drinking, smoking and using other substances such as sniffing solvents.

The YHP is responding to these issues through a number of strategies directed at an individual, family, and community level. Peer education training materials include information on drugs, health and lifestyle choices. Additionally adolescents have been trained in street theatre including writing scripts, songs and poems on healthy lifestyle choices. Young people have themselves written dramas on the negative health consequences of tobacco and alcohol consumption as part of the outreach work supported by the YHP. Poster competitions on the theme have also been organised for young people. The programme also provides counselling sessions and IEC materials at their community-based Health Information Centres, with dedicated slots for young people and also parents, and provides referral services as well.

Example 2: Specialist NGOs in partnership to improve access to services and support for young people who use drugs in Indonesia

In 2012, Youth RISE (an international youth-led network) supported Rumah Cemara (an Indonesian community-based NGO) to launch services for young people who use drugs in Bandung, Indonesia. Whilst successful in providing harm reduction services for older (30+) people who inject drugs, Rumah Cemara were not reaching young people who use drugs, particularly those who were not yet injecting. Six months later, Rumah Cemara was successfully involving 50 young people who use drugs in the programme. Many of these youth were street connected, and had little knowledge about the drugs they were using or about how to reduce harm and vulnerability to HIV, and improve their sexual health. Youth participated in a number of workshops on HIV and harm reduction, English classes, opportunities for creative expression, sport activities, and were provided with a safe place at Rumah Cemara where they could talk to staff about their concerns and needs.

In 2013, the programme held a workshop on 'problem solving', and the youth learnt skills on how to solve problems that arise in their daily life. Discussions also focused on being positive, creative, and accepting that reality may not be the same as what we expect. The programme adopts a holistic approach and understands that drug use is just one aspect of a young person's life that needs to be addressed. The programme is also highly participatory, engaging the youth at all levels of the programme's design and implementation of activities. <http://www.cahrproject.org/news/indonesia-works-with-young-drug-users/>

Points for reflection

- » Programmes need to consider how drug use influences other risky behaviours such as violence and unsafe sex.
- » Much drug use is influenced by multiple causal factors that go beyond the individual level, and therefore responses need to go beyond intervention at the individual level.
- » There needs to be a transformative approach to programming with young people who use drugs. Simplistic, abstinence-only messaging is ineffective.
- » A significant factor hindering effective programmatic responses is the high level of stigma (and in some cases criminality) associated with drug use.

Additional resources on young people and drug use

Barrett, D., Hunt, N., and Stoicescu, C (2013) Injecting drug use among under 18s. Harm Reduction International, London 2013. http://www.ihra.net/files/2013/12/12/injecting_among_under_18s_snapshot_WEB.pdf

DrugScope (2006) Drugs: Guidance for the youth service. A summary. DrugScope <http://www.drugscope.org.uk/Resources/Drugscope/Documents/PDF/Education%20and%20Prevention/Drugsguide%20sum.pdf>

EHRN (2009) Young people and injecting drug use. Eurasian Harm Reduction Network and Youth RISE, Vilnius, Lithuania. http://reformdrugpolicy.com/wp-content/uploads/2011/09/young_people_and_drugs_2009.pdf

ERHN, Harm Reduction International and Youth RISE (2011) Drug use, drug dependence and the right to health under the UN Convention on the Rights of the Child. Submission to the UN Committee on the Rights of the Child: General Comment on Article 24. Harm Reduction International. http://www2.ohchr.org/english/bodies/crc/docs/CallSubmissions_Art24/HRI_YouthRISE_EHRN.pdf

UNODC (2002) A participatory handbook for youth drug abuse prevention programmes: A guide for development and improvement. United Nations Office for Drug Control and Crime Prevention, New York. http://www.unodc.org/documents/drug-prevention-and-treatment/E_handbook.pdf

UNODC (2004) Schools: School-based education for drug abuse prevention. United Nations Office for Drug Control and Crime Prevention, New York. http://www.unodc.org/pdf/youthnet/handbook_school_english.pdf

Youth RISE (undated) Harm reduction and young people briefing paper. Youth RISE, London. <http://www.youthrise.org/sites/default/files/files/Harm%20Reduction%20and%20Young%20People.pdf>

Snapshot Four – Mental health needs

Learning outcomes:

1. To consider how mental health is an issue for adolescents, and how it interlinks with other areas of health
2. To discuss the importance and benefit of youth-adult partnerships in the creation, development, implementation and evaluation of new resources and tools for mental health
3. To reflect on the role of digital technology in cultivating partnerships with youth for mental health

What is mental health?

Mental health can be described as a state of well-being in which the individual realises his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully and is able to make a contribution to his or her community.

Many physical diseases are related to or influence mental health, prompting WHO to declare that there can be **‘no health without mental health’**.⁵⁸

How do mental health problems affect adolescents?

In any given year, about 20 per cent of adolescents will experience a mental health problem, most commonly depression or anxiety. The risk is increased by experiences of violence, humiliation, devaluation and poverty. Suicide is one of the leading causes of death in young people. The risk factors associated with mental health problems include gender, ethnicity and socio-economic status. These interact with psychosocial environmental factors such as neighbourhood, occupation, violence, sexual coercion, trauma and rapid social change. Rapid social transformation, driven by the compounded impact of globalisation, economic and financial crises, and cultural dislocation are often associated with high rates of substance misuse, self-harm and suicide, which all fall within the broader mental health agenda. Stigma associated with mental health problems contributes to delayed help-seeking and exacerbates problems.

How can programmes respond to adolescent mental health needs?

The socio-ecological approach can be applied to mental health programmes for adolescents, taking the context into account. Special attention needs to be paid to human rights, as recipients of services are often in a vulnerable position.

⁵⁸ WHO (December 2010), *Mental health: strengthening our response*, Fact sheet N°220.

Intervention at individual level

- » Building life skills from a young age, providing psychosocial support, counselling provided by competent and caring health workers, providing autonomous access to information.

Intervention at family level

- » Parenting skills training, information materials on prevention and recognition of early signs.

Intervention at peer level

- » Peer education programmes delivering life skills education, awareness raising on recognising and responding to depression and abuse.

Intervention at community level

- » Health worker home visits and monitoring for suspected abuse or developmental disabilities, campaigns to address stigma attached to mental health problems, providing telephone helpline services.

Below is an example from the YHP using innovative strategies to work with vulnerable young people on mental health in a developed country context.

Example: Mindyourmind empowering youth in Canada around their mental and emotional health needs



Issues: Youth in Canada have a higher rate of unmet mental health care needs than all other age groups in the country.⁵⁹ Eighty per cent of all mental health problems develop in adolescence⁶⁰ yet approximately only half of Canadian adolescents exhibiting serious mental health issues access mental health services.⁶¹ With regards to the needs and preferences of adolescents, young people experience various barriers prior to and when accessing mental health services and are reluctant to seek help.⁶²

Key barriers include fear and embarrassment and a lack of knowledge around mental health issues.⁶³ For the best outcomes young people need to seek help early for mental health problems.⁶⁴

⁵⁹ Statistics Canada (2002) *Canadian Community Health Survey: Mental health and well-being*. Accessed at <http://www.statcan.gc.ca/daily-quotidien/030903/dq030903a-eng.htm>.

⁶⁰ Health Canada (2007) *Reaching for the top: A report by the Advisor on Healthy Children and Youth*. Accessed at http://www.hc-sc.gc.ca/hl-vs/alt_formats/hpb-dgps/pdf/child-enfant/2007-advisor-conseillere/advisor-conseillere-eng.pdf.

⁶¹ Cheung, A. and Dewa, C. (2007) Mental health service use among adolescents and young adults with major depressive disorder and suicidality. *The Canadian Journal of Psychiatry*, 52 (4).

⁶² Jagdego, A., Cox, B., Stein, M. and Sareen, J. (2009) Negative attitudes toward help seeking for mental illness in two population-based surveys from the United States and Canada. *The Canadian Journal of Psychiatry*, 54(11), 757-766.

⁶³ Gulliver, A., Griffiths, K. M., and Christensen, H. (2010) Perceived barriers and facilitators to mental health help-seeking in young people: a systematic review. *BMC Psychiatry*, 10(1).113.

⁶⁴ Ibid.

To access adequate mental health support, youth first must have knowledge about mental health that equips them with the right language and competency to navigate the system. Readily available services that meet the needs and preferences of youth are more likely to be accessed when needed.

YHP approach: Through partnership with YHP, **mindyourmind** reaches youth aged 14-18. Youth are partners in multiple, flexible ways: as participants, collaborators, advocates and volunteers at **mindyourmind**.

Interventions at the individual level

mindyourmind is empowering youth to reach out for help around mental and emotional health problems and equipping youth to be a support for peers experiencing these issues. Their programme actively uses digital technology and social media to engage youth in these goals. With youth and for youth, **mindyourmind** co-creates tools and resources that are informed by youth voices and experiences. The goals are to impact knowledge, self-awareness, decision making and help seeking. Both the partnership process with youth and the digital tools and resources developed assist youth in coping with everyday challenges as well as crisis events, which contributes to their resilience and overall positive mental health.⁶⁵

Interventions at the community level

mindyourmind also works with the professionals working with youth including health care and other youth care providers. Encouraging professionals to shift their culture around more effective ways to engage youth is an essential part of the equation and is part of the YHP/ **mindyourmind** mandate. Through the YHP **mindyourmind**, youth and professionals have collaborated to co-create mytoolkit.ca, a web-based, interactive resource in both French and English aimed at people who work with youth. The main goal of mytoolkit.ca is to provide a starting point for adults and youth to have a well-informed youth-friendly discussion about mental and emotional well-being. The toolkit consists of four components:

1. A-Z Wellness is a self directed, plain language comprehensive module covering topics on mental and emotional wellness with a detailed facilitator guide and activity suggestions for people to promote and talk about mental wellness in their communities;
2. A-Z Stress is a self-directed, plain language module that covers topics in depth around stress and its impact on mental health;
3. Mind Your Mood is an app that helps youth track their mood and behaviour patterns over time on their mobile device and encourages them to reflect and share patterns with a support person, opening up a place for common language; and
4. A series of one minute videos touching on the current issues around youth mental health in Canada with a call to action to start a conversation and share the videos.

⁶⁵ Oh, E. (2009) Perceived helpfulness of websites for mental health information. *Social Psychiatry and Psychiatric Epidemiology*. 44 (4); Rickwood, D. (2007) When and how young people seek professional help for mental health problems? *Medical Journal of Australia*, 187:S35-S39.

During 2013, individual components of mytoolkit.ca have been launched and disseminated through national conferences and national media channels, and online through social media, reaching thousands of professionals and youth. Continued active roll-out strategies with YHP partners Boys and Girls Club Canada and Physical & Health Education Canada, as well as **mindyourmind's** many community partners at the ground level, is key to successful dissemination and uptake and will continue throughout the year. Results will strengthen our understanding of the impact of technology on the engagement of youth and adults and it will be important to share learnings with others.

Points for reflection

- » Mental health challenges often stem from young peoples' daily lives and circumstances. Early recognition and intervention can help young people cope better with their circumstances and may assist in disease prevention.
- » Digital resources and tools can meet the developmental needs of youth who seek more autonomy. These resources don't replace, but augment in-person support.
- » Peer to peer relationships enhance learning about and coping with mental health issues. Youth-adult partnerships are empowering and encourage growth of all partners.

Additional resources on mental health:

Braddick, F., Carral, V., Jenkins, R., and Jane-Llopis, E. (2009) Child and adolescent mental health in Europe: Infrastructures, policy and programmes. Luxembourg: European Communities. http://ec.europa.eu/health/ph_determinants/life_style/mental/docs/camhee_infrastructures.pdf

Cohen, A. and Minhas, H. (2010) Mental health etiology: Social determinants. In Heggenugen, H. and Quah, S. (eds.) International encyclopaedia of public health. Academic Press, San Diego.

Lancet Series on Global Mental Health, 2007 <http://www.thelancet.com/series/global-mental-health> and 2011 <http://www.thelancet.com/series/global-mental-health-2011>

Remschmidt, H., and Belofer, M. (2005) Mental health care for children and adolescents worldwide: a review. World Psychiatry 4 (3) 147-153. http://wpanet.org/uploads/Publications/WPA_Journals/World_Psychiatry/Past_Issues/English/wpa-10-2005.pdf

WHO (2005) Psychosocial support for children and adolescents. World Health Organisation. http://www.who.int/maternal_child_adolescent/documents/pdfs/psychosocial_support.pdf

WHO (2012) Adolescent mental health: Mapping actions of non-governmental organizations and other international development organizations. World Health Organisation. http://whqlibdoc.who.int/publications/2012/9789241503648_eng.pdf

Plan is a global children's charity. We work with children in the world's poorest countries to help them build a better future. A future you would want for all children, your family and friends. For over 70 years we've been taking action and standing up for every child's right to fulfil their potential by:

- giving children a healthy start in life, including access to safe drinking water
- securing the education of girls and boys
- working with communities to prepare for and survive disasters
- inspiring children to take a lead in decisions that affect their lives
- enabling families to earn a living and plan for their children's future.

We do what's needed, where it's needed most. We do what you would do.

With your support children, families and entire communities have the power to move themselves from a life of poverty to a future with opportunity.



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