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REPRODUCTIVE HEALTH IN ADOLESCENCE

POSITION PAPER

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The Reproductive Health in Adolescence Programme
Position Paper

Preamble

The philosophy of health espoused by WHO incorporates the notion that a basic problem underlying interhuman tensions is low self-esteem arising from the lack of fulfilment of human potential through healthy development. Health development, in turn, is dependent upon adequate nurturing, especially by parents during the crucial growth phases of childhood and adolescence. But parents need the maturity to provide such care and when children are born to those who are not able to meet those needs a cycle of deprivation is begun with consequences for the parents, the child, and all of society. This is a problem which is being experienced not just in developing societies which may have a tradition of early childbearing (albeit with the support, in the past, of the rapidly vanishing extended family) but in some 'developed' societies as well, in which there is an alarming increase in adolescent parenthood. There is thus an urgent need to ensure that young people do not become parents before they are ready, and that when they do they will be prepared for it. Society has a responsibility to provide such preparation through the people who interact with and influence the adolescent population. Such key people - parents, teachers, health providers, youth and religious leaders, for example, are in the best position to provide such guidance if policy makers in their own societies give them the tools, i.e., the knowledge and skills to help the young. But young peoples' healthy development and the self-esteem which accompanies it is dependent not merely on what is given, but on the experience of success in their activities and in their relationships with each other, with adults, and with children too. The Reproductive Health in Adolescence (RHA) programme of the WHO is dedicated to the enhancement of the health of adolescents with special regard to their role as parents of the next generation. It recognizes the need to support, through governmental and non-governmental agencies, those in positions crucial to adolescent health - the policy and decision makers, the service providers who interact with adolescents in all sectors, and young people themselves who, given the opportunity, are in the best position of all to promote health.

In May 1985 the World Health Assembly passed a resolution which:

1. URGES all Member States to act immediately:

    (1) to promote the delay of childbearing until both prospective parents, but especially the mother, have reached maturity in aduldhood;

    (2) to promote healthy families through the provision of adequate information and guidance for responsible parenthood to adolescents;

    (3) to ensure that their populations are aware of the need for both prospective parents to be fully grown, adequately nourished, and disease-free before conception;

    (4) to ensure that health, education and social service providers are enabled to provide sound, culturally acceptable information and guidance; and

2. REQUESTS the Director-General:

    (1) to encourage collaborative action-oriented research on both biomedical and culturally relevant social factors contributing to the prevention of pregnancy before the couple are biologically and socially mature, and on the adverse consequences of pregnancy and childbearing in adolescence;

    (2) to increase the Organization's collaboration with Member States and their relevant governmental and nongovernmental agencies in providing primary health care with the emphasis on promotive and preventive programmes for adolescents including family life education, antenatal, delivery and postnatal care, and supporting family services as an urgent step in the implementation of the 1978 Declaration of Alma-Ata.

It is partially in response to this request that this proposal to enhance and extend the work of the RHA programme of the Maternal and Child Health Unit of the Family Health Division of WHO, is addressed.

Introduction:

In recent years the adolescent populations of developing countries have come to be seen as crucial to achieving the goal of "health for all by the year 2000". This is so for two major, but quite different reasons stemming from the vast increase in the size of this population both in absolute terms and relative to other age groups. The magnitude and the nature of the problems experienced by adolescents has changed in some alarming ways, but so too has the recognition that a healthy young generation is a resource of great potential which can make an essential contribution to the health of society as a whole. It is a contribution which, in fact, is uniquely dependent upon them for only they are the parents of the next generation.

Since its inception approximately ten years ago, the RHA programme of the Maternal and Child Health Unit, Division of Family Health, WHO/HQ has focussed on facilitating country activities designed to prevent and alleviate problems arising from unprotected sexuality in the adolescent populations. These include unwanted pregnancies, maternal and child morbidity and mortality, induced abortion, sexually transmitted diseases, and premature parenthood. This last state, well documented in both developed and developing countries, stunts the economic, social psychological and educational development of young people who become parents before they are sufficiently mature to rear healthy children and not only affects themselves but often leads to a more rapid childbearing career. This in turn places their new families in a poverty cycle and contributes to the too rapid population growth characteristic of many developing societies.

By providing technical support through workshops, publication and the development of methodologies to improve health planning, the RHA Programme has contributed to an increase in the awareness of problems in adolescent health and facilitated essential activities to overcome them especially in the domain of health systems reasearch. While more and more countries are asking for such support, there has also been a rise in the wish for systematic direct action. To this end a number of innovative approaches have been identified and, in a few cases implemented, but it has also become abundantly clear that there are barriers to the implementation of such activities which must firstbe overcome. This proposal is written in response to the demands that further technical support be provided both to expand the on-going activities to countries not yet in the programme, and to facilitate the pathway between research and direct action by reducing the barriers in their way.

In what follows the current RHA programme is described, its major findings to date summarized with special attention to the barriers in the way of promoting adolescent health, and future activities to diminish these barriers are proposed.

The Current RHA Programme

a) The health problems

The problems which this programme was devised to address arise from major changes taking place in developing countries. These include an apparent decrease in the age of menarche and a rise in the mean age of marriage thus extending the period of risk of unprotected sexual intercourse with consequent dangers of unwanted pregnancies, maternal and child morbidity and mortality, induced abortion, sexually transmitted diseases, the danger of future infertility, and premature parenthood damaging to the whole family. While there was some scattered evidence available to suggest that these were increasing problems, there was very little systematic local research and an understandable reluctance to take steps to alleviate problems until they were adequately identified. What was known however, was the population trends which show a very high growth rate for the adolescent and youth populations: from 1960 to 1980 the world's population increased by 46% while that of young people rose by 66% and in the developing world by 79%. Furthermore, for the age group between 15 and 24 some 78% currently live in developing societies, and that is projected to be 84% by the year 2000. A second major factor that was recognized was the rapid urbanization of societies: From 1950 to 1980 the percent

living in urban areas changed from 29 to 41 and it is projected to be 51% by the year 2000. In societies that have been mainly rural this transition has much more serious consequences than in industrial societies for it is rare for the necessary health, economic and educational infrastructures to exist in the new urban and peri-urban areas.

For many such societies the transition often means a change from a traditional structured rural society in which the young individual has the support of the extended family and in which the roles that young women and men were expected to fufill as adults were very different from each other but much the same as their parents - to an urban industrial environment where young people often migrate alone, where the skills they need are increasingly difficult to obtain, where they are exposed to new and often alien ideas from mass media, tourists and returned migrant workers, and where commercial interests stoke their aspirations in ways which their societies cannot meet. To address these problems the RHA programme has undertaken the following activities:

b) Programme activities

1) Following technical working groups and consultation with regional offices, a jointly funded IPPF/WHO cross-cultural study on family life, education and services available to adolescents was done, and reported on at a meeting in Mexico city.

2) A series of inter-regional and regional workshops have been held to facilitate planning by bringing together participants from countries having expressed an interest in adolescent health. A methodology for planning adolescent health service research was developed and published and this "Grid Approach" has been extensively used in these workshops which have taken place in Malaysia, Thailand, Portugal, and Morocco with additional ones planned from Asia, Africa and Latin America. The workshops provide an opportunity to heighten the awareness of countries of the nature of problems, the variety of services and interventions which can be used, and provide some training in research planning. The methodology has continued to be refined and expanded to facilitate decision making at the local level.

3) A series of studies have emerged from the workshops. These include developmental studies of menstruation, ovulation and spermarche among young people in Hong Kong, Israel, Sri Lanka, Sweden and Switzerland. The purpose of these initially was to develop appropriate methodologies and subsequently to establish local norms for healthy development which can be used for screening purposes and in health education programmes.

4) The outcome of pregnancy to young adolescent mothers in comparision with those from 18-25 is part of the programme in the Republic of Korea, Malaysia and Turkey. The nature of both bio-medical and psychosocial factors in maternal and child health are being explored in these studies and have proved useful in bringing to light locally the hazards of too young motherhood, as well as, in some cases, pointing to insufficiencies in health service effectiveness.

5) The behaviour and views of young people in regard to their sexuality and use of contraception has been the focus of studies in Cuba, Mexico, Nigeria, Sri Lanka and Yugoslavia. The barriers to the use of contraception by the young have been highlighted by these studies and are being used to compare other findings derived from health service providers. Such studies, of the perceptions and behaviour of health workers are taking place in Cuba and Portugal and are planned for other countries.

6) Some action programmes have already begun as outgrowths of rsearch. In Sri Lanka a systematic development of sex education for in school adolescents is underway. In the Republic of Korea as part of a follow-up study an experimental provision of telephone counselling to young workers in an industrial part of the capital is beginning. The use of drama with youth participation is underway in Kenya, and plans have been laid for activities tailored directly for youth in Jamaica.

7) For these various projects, guidelines, research instruments and formats for data analysis have been developed and distributed for wider use.

8) Dissemination of the work of the Task Force on RHA has taken place through publications and papers, participation in international meetings, and the activities of the members of the Steering Committee.

Among the publications which have emerged from the RHA programme are two in the WHO technical report series - Pregnancy and Abortion in Adolescence, and Health Needs of Adolescents; an offset publication (No. 77) on the planning of health service research for adolescent reproductive health; a report of IPPF/WHO cross cultural survey mentioned above, reports of all the worskhops held, two reviews of biomedical and psychosocial contraception in adolescence, published in the WHO bulletin; studies of menstruation for publication in the Journal of Adolescent Health Care, and reports of meetings on contraception and on methodological issues.

9) In addition to the RHA programme, activities for the International Youth Year (1985) for which the focal point has been MCH has stimulated progress toward a greater level of participation of young people in the promotion of their own health and that of their societies, especially through primary health care. Toward this end a study group on "Young People's Health - A Challenge to Society" was held in Geneva, and the report of this study group will appear this year in the WHO Technical Report Series.

c) The Interim Findings: Barriers to Health

Each of the activities described above have produced findings of significance for the future directions of the RHA programme, as well as data of local importance. Emphasis here will be placed on the barriers identified to the furtherance of adolescent health.

1) The studies of growth and development have successfully tried out methodologies for studying the onset of menarche which has value in the local context in that it provides data for norms appropriate to that society. However, it has also often provided an entrée into the whole question of adolescent sexuality which is frequently a more controversial subject. For societies which are as yet too anxious to approach such questions directly, maturation studies can serve this other purpose.

2) The outcome of pregnancy studies appear to be confirming the evidence from other societies that pregnancy prior to the age of 18 is likely to be more hazardous than in the following decade. The data also suggests, however, that young people are less likely to use health services for antenatal care, and when they do, are more likely to come late in the gestation period. There appears to be anxiety because they are pregnant and (frequently) unmarried, they are uncertain of the kind of reception they will receive from health workers, they may be ignorant of the signs of pregnancy until later than a more mature woman, and they may simply not know how to go about getting help. Action is needed to reduce these barriers which create gaps between adolescent health needs and the services which already exist.

3) The surveys of young people's behaviour, beliefs and perceptions about sexuality and contraception often indicate not only ignorance about reproductive health matters, but an uncertainty about what is appropriate behaviour, and a great reluctance to approach people in positions of authority, including frequently, their own families. Information is certainly needed, but information alone is insufficient. The establishment of trust so that young people can confidently approach knowledgeable adults for guidance and counselling needs to be established. One pilot study in a developing country showed an increase in biological knowledge from the age of 13-15 but a decrease in the accuracy of information about sexual matters. It is likely that as their interest grew they asked more questions, but of other young people equally uneducated who gave them misinformation. Are many young people right to believe that they won't get the answers to the questions worrying them if they do go for help?

4) The studies of health workers who do or might interact with the adolescent population tend to lend support to this belief. One of the most common findings appears to be an uncertainty on the part of the health worker as to how to communicate with young people on hitherto taboo subjects like masturbation and sexual intercourse, and how to use some contraceptives, but also hint at a lack of fundamental knowledge themselves. After all they have not themselves had systematic sexual education when they were growing up. How can they be asked to respond to young people's needs today without giving them further help first.

5) The workshops themselves, which have been central to the activity of this programme, have been instrumental in identifying the needs as policy makers and administrators see them. It is clear that the will is there to prevent the problems of adolescent reproductive health as well as provide curative approaches. While once they were seen as relatively peripheral to health needs, adolescents are being increasingly recognized as having problems which require urgent attention. But there is often a reluctance in policy makers to acknowledge the extent (even if only suspected) of the spread of sexually transmitted disease, or of illegally induced abortion. There is a reluctance on the part of policy makers to introduce programmes to provide sexual education and often contraceptive services including counselling to the young and unmarried lest they be accused by their constituents, the parents, of stimulating sexual activity in these groups. There is clearly a need for informing the public so as to bring about a greater understanding of the value of prevention, in comparison with treatment after the damage has been done.

6) Even when an effort is made to implement such policies, however, the managers and administrators of services, whether they be in health, education, social welfare, or other sectors, will, usually quite rightly, say that they haven't sufficient trained staff to carry out such programmes

Thus, the activities of the RHA task force have shed light on the barriers between identification and clarification of the problems which exists, and the barriers preventing direct action to promote reproductive health. These include the sensitivity of public officials to acknowledge sexually related problems in this age group, the reluctance of administrators to deploy staff who are trained for other things, the anxiety of the health workers and educators themselves because of their own lack of knowlege in these matters, and lack of training in communicating with the young on such subjects, the anxiety of the families of adolescents that they will be corrupted, and not least, the lack of knowledge of the adolescent about what services do exist, and the reluctance to make use of them lest they be censured by adults. In the next section we discuss ways in which WHO can help to facilitate the lowering of these barriers.

d) Future directions: the lowering of the barriers

1) One of the best ways found to date to deal with the sensitivity of policy makers to the introduction of sexual education and contraceptive services for the unmarried adolescent has been the workshop approach which includes policy makers when possible, and exposes them to a cross section of ideas stimulated by the grid approach. Participants have repeatedly indicated that one of the most valuable aspects of the methodology is the requirement that all aspects of the subject matter be discussed in order to complete the grid regardless of what may be taboo in their own countries. The grids provide 'permission' and the cross cultural context makes it acceptable to be exposed to ideas that are less acceptable in the local context. It also provides special methodology (such as the gatekeeper approach) for moving key figures to initiate or accept action. Taking the results of an interregional workshop into national worskhops can facilitate further action in the directions indicated.

2) In order to multiply the effect of the workshop approach efforts should be made to train facilitators and to this end special workshops designed for immersion in the methodology for key participants from regions is likely to be the most cost effective way to achieve the multiplier effect. Training in the systematic planning of action, in research and evaluation methodology form an integral part of such a facilitators workshop.

3) One of the planned activities of the RHA programme is to strengthen the methodology for greater autonomy in use at the local level. Modules for training in special aspects which emerge from the grid procedure are proposed for further development.

4) One of the major problems which inhibits managers of health and education programmes from deploying staff to interact with the young on sexual matters is the lack of training in communication and the lack of education in the specific subject matter of adolescent sexuality, information which is usually lacking in their own professional training. A useful approach to the sensitisation of such key people, to providing them with training in communication, and to providing technically sound knowledge for them to

use, is the RHA counsellor training workshop currently being proposed. This is to be an intersectoral approach in which key people are exposed to basic information in the subject matter of RHA and given some intensive exposure to counselling techniques so that they can identifiy approaches most suitable to their communities.

It should alo enable them to evaluate further training in counselling for themselves for more junior members of their staffs.

5) The anxiety of the young in going for help to sound sources as indicated above, is a mixture of accurate perception that they won't get the help they need, and possible misinformation about what would be most helpful to them. Young people need to be educated in consumerism. They need to be helped not only to understand the subject matter through basic education, but also how to ask the questions that will give them the necessary guidance, whom to approach for this help, and how to go about getting it. Many among them will be perfectly capable of being trained themselves for peer counselling and for communicating health information to other members of their famillels. To this end it is proposed to develop special programmes for consumer enducation in relation to health, welfare and educational services at the local level, in selected countries which may serve as models for other societies not yet at that stage. Already established links for coordination with National Youth Councils and other youth groups will greatly facilitate this process.

6) Some innovative action projects with youth participation are in the course of being identified and a few have been implemented. More intensive efforts, particularly with the participation of national youth councils need to be started. Some techniques for tapping into such rich sources of information and cooperation have already been developed. Youth organizations offer a special forum for obtaining candid views from young people outside the constraints of school and places of work. They are also frequently eager to make contributions to the health of all through their (sometimes) vast memberships.

7) The approaches above are designed to reduce the barriers unilaterally between health workers and the young, but a further step is necessary and desirable, and that is the implementation of seminar/workshops in which a direct dialogue can take place between representatives of both with a view toward establishing such give and take ultimately at places of primary and secondary health care.

8) A further step in that direction is the facilitation of dialogues between health and educational professionals, young people and their parents. Parents need and have the right to be kept informed of changes in the provision of health care and in the promotion of health. They also have a valuable contribution to make, but local circumstances will be paramount in how that takes place.

9) Preparation for parenthood. While the emphasis of the programme has been on the prevention of pregnancy it is clear that many adolescents will have babies, and for them and their families it is vital that they be helped to be good parents. This applies, of course, to boys as well as girls and programmes are needed for couples to prepare for family life. The importance of spacing births cannot be overestimated for it not only gives greater opportunities for health to the children, and greater resources for the family, it is a safeguard for the mother's health, for future births, for the reduction of national maternal and child mortality figures, and for keeping population growth at a reasonable level. In many societies still it is difficult to delay the first birth since it is seen as proof of fertility or potency. However, educational campaigns directed toward future health can have a major impact on spacing. The combination of delaying the age of the mother at the first birth, and increasing spacing, can, without any further modification of services, have a major impact on a country's maternal and child health. Work which facilitates and integrates the best of such programmes, can usefully be developed by WHO at the request of countries.

With this programme there is a need for identification and dissemination of major findings and methodologies through:

10) Multicentre studies

11) A Clearing House for information on current projects, and

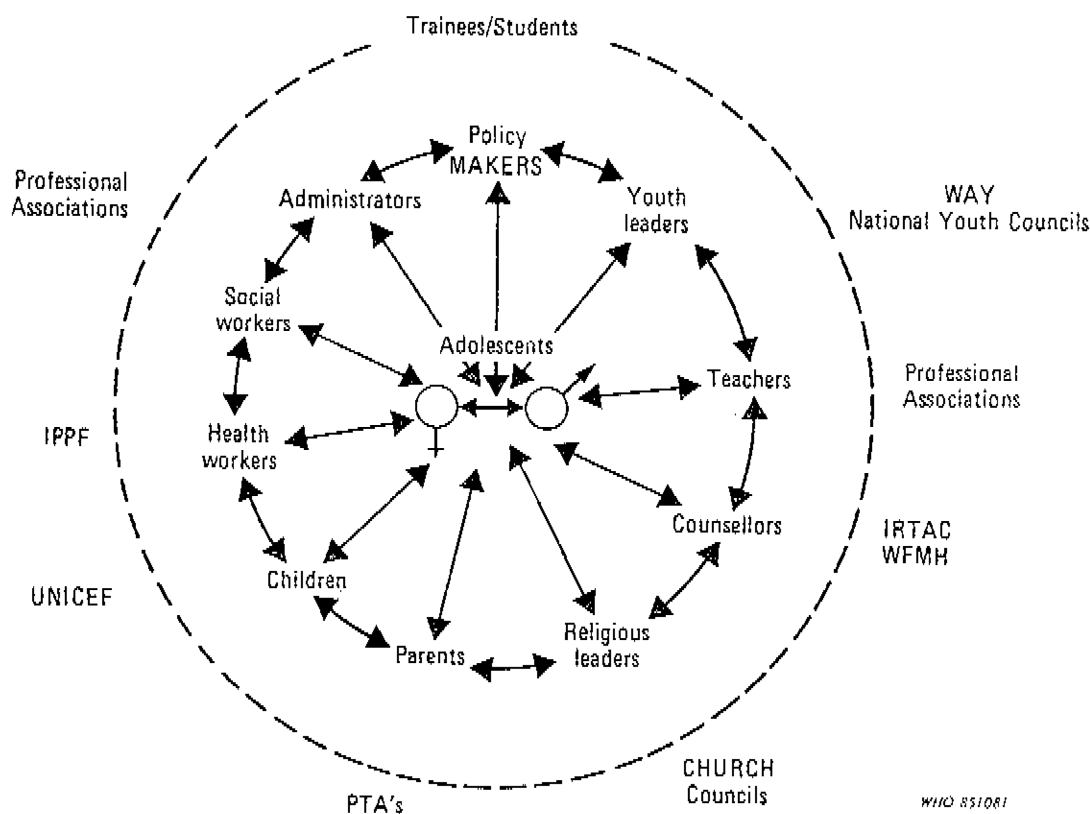
12) Publications special to this field.

As with many of the objectives described above, it isn't difficult to recognize their value, but is not easy to implement them unless the barriers to health promotion in adolescent sexual and reproductive health are first diminished. WHO has a unique status in that it is respected for its scientific standards, and its objectivity in applying them. It can only act at the request of governments within countries, or, minimally with their full approval. It cannot nor should it attempt to impose policies from without, but is able to facilitate thinking which permits change. In combination with an internationally respected NGO such as the IPPF which greatly facilitates the possibilities of direct action, a programme such as the one described in this section which naturally follows on from the activities already underway can be effectively implemented.

Underlying Methodology of the RHA Programme

Before elaborating these proposals for action it may be useful briefly to describe the methodology which has given rise to their identification and selection. Graphically, the field of endeavour of the programme, and its interaction with some governmental and non-governmental agencies may be seen below:

Figure 1



We have mentioned earlier the 'grid approach'* which has been extensively employed in workshops. Its use has clarified both the action desired at country level and the barriers to implementing them which often exist. The approach consists of using three grids identical in structure but different in content and aim. Each grid consists of ten rows and six columns though they can be varied to suit local needs. The rows specify stages and events in the reproductive status of adolescents, and the columns, different aspects of each state, which must be considered when reviewing adolescent health, as below.

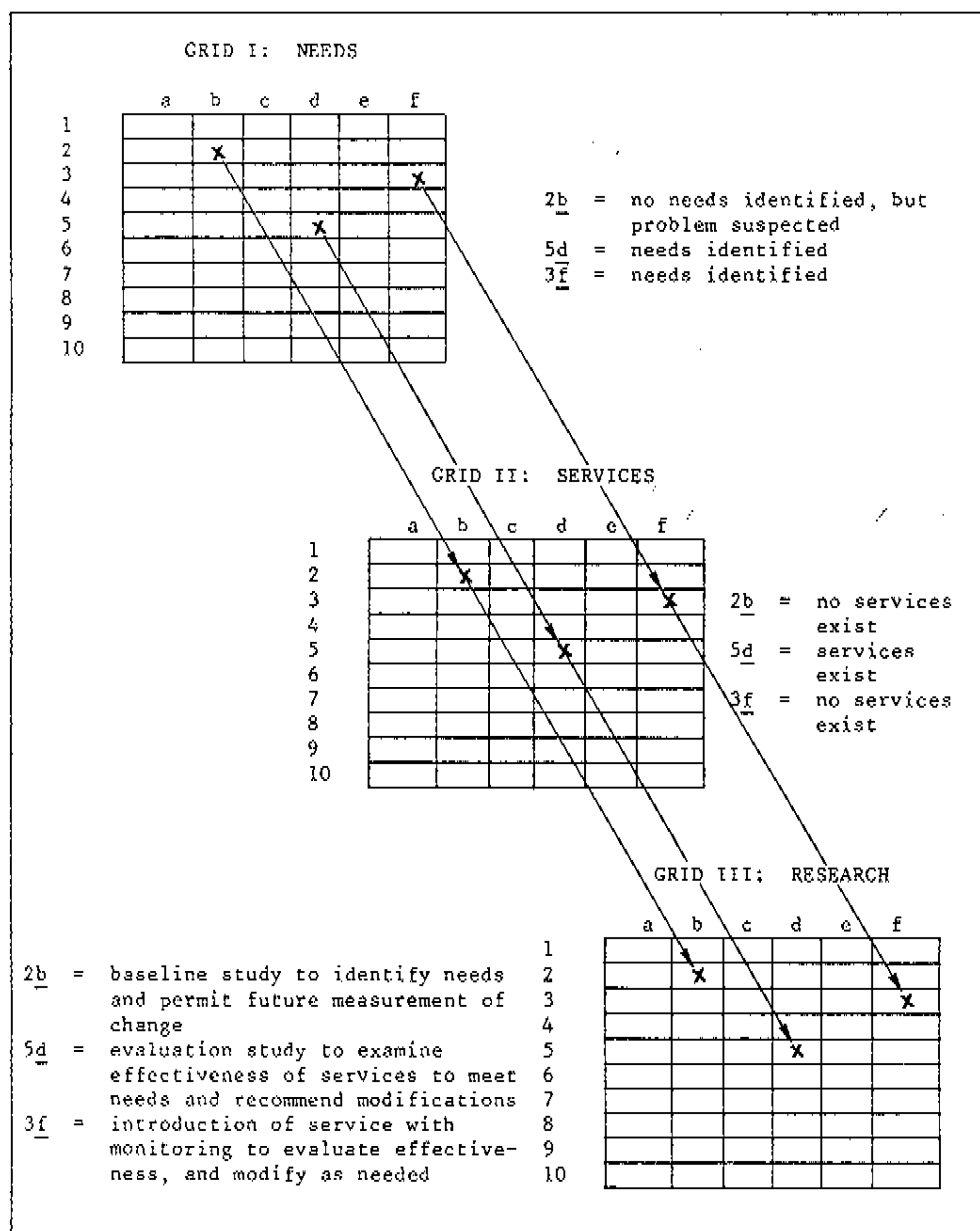
The Grid format:

Stages/events	Areas of concern					
	a)psychol	b)social	c)medical	d)educat	e)econ	f)legal
1. sexual maturation						
2. marriage/con. union						
3. sexual intercourse						
4. contraception						
5. pregnancy						
6. induced abortion						
7. spon. abortion/ stillbirth						
8. live childbirth						
9. adoption						
10.childrearing						

* Adolescent reproductive health. An approach to planning health service research, by H.L. Friedman and K. Edström. WHO Offset Publication, No. 77, 1983.

The Grid is first used to identify the needs and problems of adolescents in the participant's own society by reviewing each cell. 'Criteria' questions are asked at this time such as "for whom is it a problem", "how severe is the problem for the individual?", "how widespread is the problem?", "what is the trend of the problem?", and "how adequate is the information about these questions?". This is followed by applying the same Grid to a description of services and interventions which exist to meet the needs and problems identified, cell by cell, in completing the first Grid. Again criterion questions are applied such as "to what extent does the service alleviate the problem identified for the individual?", "what is the coverage for the target population identified?", and "how adequate is the information for answering these questions?". The third activity is a comparison of Grids I and II to identify the kind of action which would be desirable as a next step: it may be baseline research to answer the inadequacy of information for any cell; it may be modification of a service which is known to be inadequate with a research component built in; it may be the introduction of an entirely new (to the society) activity to meet a need for which there is no current intervention. (see Fig. 2)

Figure 2 A GRAPHIC ILLUSTRATION OF THE HEALTH SERVICE RESEARCH STRATEGY[1]



[1] For each grid: 1-10 = stages/events; a - f = areas of concern (see also Tables 1, 2 and 3).

This identification of alternative courses of action in the interregional workshop activities had led to employing a fourth grid to help select the actions which have been identified. It is drawn from earlier work decision theory* but is used simply as a guide to select the most cost effective next step. For each alternative course of action identified, the following characteristics of it are also considered: the costs and constraints associated with carrying it out, the outcome that it is directed to, the probability of achieving that outcome if it is done, and the value placed upon that outcome.

Figure 3

COSTS	ALTERNATIVES				
	VALUES	V_1	V_2	V_3	V_4
	OUTCOMES	O_1	O_2	O_3	O_4
C_1	A_1				
C_2	A_2			PROBABILITIES	
C_3	A_3				
C_4	A_4				

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The results of this kind of interregional and intersectoral analysis over a period of years has made it apparent that while some alternative courses of action may be highly desirable, there are constraints, not necessarily fiscal, which may make it extremely difficult to implement. For example, while most people in most societies would agree that it would be highly desirable for young people to have the best guidance in regard to their sexual activities that is available - in the cultural context of their society - any such attempt to directly influence the sexual behaviour of the young is likely to be met with strong resistance from many groups in society for a number of different reasons. Among these barriers is the anxiety that just talking about such a subject will increase sexual activity, the lack of baseline knowledge by the people who might provide help, the lack of staff willing and/or available to provide guidance, and so on. Each of these, however, is a constraint which can be reduced by intermediate action such as the kind proposed above. Intersectoral counselling workshops with key people to sensitise them to needs and provide them with skills; appropriate research which builds in policy makers from the outset such as exemplified in the 'Gatekeeper design'; and research employing the human resources and networks of national youth councils to realistically identify the needs and perceptions of the young, are examples of intermediate steps to promote effective action.

In other cases, the alternative course of action identified, may be relatively easy to implement, e.g., modifying the hours of an already existing clinic to make it more accessible to young people, once the needs have been clearly established. In the next section specific plans of action for the RHA programme are outlined.

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*Ackoff, R.

An outline of the proposed RHA Plan of Action

1. The Action/Research Training Workshop

Problem: While there is growing recognition of the need for action to promote adolescent health, what is done is often done piecemeal and without a systematic examination of all the factors needed to determine priorities and the best sequence of action to follow.

Objective: To promote the planning and implementation of action by continuing the series of interregional and regional workshops employing the grid approach.

Methodology: Workshops have been convened through the facilities of the WHO regional and country offices to date, which call on governments to nominate participants. They have, in the past, been invited from different sectors such as health and social science, and from different layers of authority such as policy makers, administrators and service providers. It is anticipated that further workshops will be held at the request of non-governmental agencies to provide the health component in the planning of their regional and country level activities.

Outcome: Specific plans of research and/or action with maximum cost effectivenss and feasibility. Updating of WHO77 offset incorporating criteria, questions and prioritization methodology.

2. Facilitator Workshops

Problem: The interregional and regional workshops conducted to date have been successful in generating projects and to a limited extent in training participants from developing countries in the action/research planning methodology employed. There have also been a growing number of requests for help with country level workshops but there remains lack of trained personnel to conduct them.

Objective: To conduct facilitator workshops to train participants in the use of the grid methodology and the conduct of intersectoral workshops with appropriate background material and technology.

Methodology: The RHA Task Force itself has a number of participants from its own global programme who have expressed strong interest in such training. There have also been indications from several NGOs that people influential in planning programmes in their regions are also interested. It is proposed to convene such facilitator workshops in locations central to the participants using materials already developed, but requiring further refinement and development to provide optimal autonomy.

Outcome: Highly trained participants with strengths at country level able to conduct intersectoral planning workshops specific to adolescent health needs in their own countries. Sets of guidelines specific to facilitator workshops.

3. The Microcomputer Software for Workshop Autonomy

Problem: While considerable material for the running of workshops has aleady been developed and used, continual feedback has suggested ways of refining the procedures. Furthermore, there is a need to provide guiding material appropriate to and in a format which can be used at country level by trained facilitators. The microcomputer is a natural device for such exposition, but further work is needed to that end.

Objective: To make available for microcomputer use, a) programmes taking the user through the training steps of the grid approach methodology, b) a system for establishing a network for information within and between centres.

Methodology: The grid approach will be further refined for microcomputer use incorporating, in addition to the Grids which currently identify the adolescent health Needs/Problems; Service/Interventions and Research/Action; the fourth grid for prioritization of action and the procedural questions for each grid by which training proceeds. This will be done through the use of consultant help and small working groups.

Outcome: Easily understood and highly transportable system and software for use on microcomputers to train methodology for adolescent planning using the grid approach, and providing for ultimate networking of information to complete the cells of the grids at national level, and for international use.

4. Counselling Workshops

Problem: One of the major problems which inhibits managers of health and education programmes in developing countries from deploying staff to provide guidance to young people in relation to their sexual feelings and behaviour is the lack of training in communication and the lack of education in the specific subject matter of adolescent sexuality, information which is using lacking in their own professional training as well.

Objective: To provide technical support for workshops on adolescent counselling to those who will manage programmes, or themselves provide services to young people.

Methodology: In response to a series of requests for technical support in developing countries an outline has been prepared for counselling workshops incorporating information about healthy development, anxieties about normal and abnormal development, and training in communication, assessment and in counselling skills for intersectoral workshops. The workshops incorporate techniques for deriving local adolescent needs for use in the workshops at country level. However, it is also anticipated that counselling workshops will be provided for interested staff at regional levels.

Outcome: A module including guidelines and materials for use in a series of workshops at country level, intersectorally, and for international staff to help them to provide counselling or to select staff for further training. As there is considerable interest in improving the training of medical, health and educational students and trainees, and those of youth leaders, it is anticipated that such a workshop will have wide application.

5. Consumer Education for the Young

Problem: It is often difficult for young people to go to knowledgeable sources for help with their anxieties not only because such people may be few in number in their communities, but because of ignorance of who to see where, and what to ask for. There is a need for young people to be assisted in ways to reach appropriate help and use it well.

Objective: Dissemination of guidance to young people on how to use the most appropriate resources available to them.

Methodology: Through means of NGO's an intersectoral approach will be developed providing guidelines to: a) clearly identify the nature of difficulties facing young people in their communities for which they want help by means of a research design tailored to that purpose. (the use of anonymous questions through youth groups is one of the more promising routes which has emerged, and b) techniques for disseminating that information in the most effective ways (e.g. radio, telephone in urban centres, leaflets, youth groups, live theatre performed by the young, are some of the ways already in use.

Outcome: A module for the development of a consumer educational package for the young to make optimal use of services which already exist in their communities.

6. Youth Participation

Problem: There is a great need for young people, especially in developing countries, to play a major role in the promotion of health for themselves and their communities. This opportunity is far from being realized however, and catalytic action is needed to facilitate this for the healthy development of individuals and societies.

Objective: Strengthening the health component of national youth councils and non-governmental organizations who can utilize young people to serve as promoters of health to their families, organizations in their communities.

Methodology: In coordination with international NGO's such as the World Assembly of Youth, a package of technical support can be provided and implemented, including: a) appropriate research designs for young people to determine their own health needs and perceptions, b) training workshops in counselling techniques which also incorporate education in development and sexuality of the young, and when appropriate, c) participation in courses for responsible parenthood (see below).

Outcome: A strengthening of the capacity of young people to contribute to the promotion of health for all by systematic support to young people through their national youth councils. Sets of materials for each of the purposes indicated in the section above.

7. Adolescent/Service Provider Seminars

Problem: While it is important to facilitate the skills and knowledge of both young people and the adults who interact with them professionally, ultimately it is necessary to bring them together. There is very little of such activity currently available in developing countries.

Objective: To facilitate constructive systematic interaction between adolescents and the service providers with whom they can interact.

Methodology: The development of the workshop methodologies for action/research and counselling training suggest a further form of workshop based on initial research into the interactions between service providers and the adolescent (currently underway in several countries of the RHA task force). The nature of perception which young people have about services and those who provide them often differs markedly from the perceptions of the providers. A model for small group seminars which is not confrontational but conducive exchanges is to be developed for use at country level.

Outcome: Heightening of understanding between the adolescents who need services in all sectors, and those who provide them through the medium of especially designed seminars. Guidelines for their conduct.

8. Adolescent/Parent/Service Provider Seminars

Problem: The health needs of adolescents are sometimes not met through default, i.e. a lack of awareness of what they are combined with an assumption that others are dealing with them. It is sometimes the parents of schoolgoers who believe that teachers are meeting adolescent needs for more intimate knowledge about sexual and reproductive health matters while at the same time the teacher (or the health worker) may believe that the parents are dealing with it. There is a need for more interaction between these groups.

Objective: To provide a forum for systematic exploration of the health needs of adolescents in relation to parents as well as those from the service sectors who may meet them.

Methodology: As for the adolescent to service provider seminars a similar forum needs to be developed for a three or four way discussions which include interested parents. The inclusion of parents is highly important and highly sensitive so that special techniques assuring maximum cooperation, a constructive atmosphere, and a positive result is needed. The combination of sound research in advance of such a meeting will be stressed and techniques provided for achieving it such as the 'gatekeeper' design which asks the participants in advance to identify what they wish to know and what would help them most, and what they would like to see result. Where counselling workshops have preceded such encounters the staff who have been trained can use their skills for this. It is anticipated that such seminars will be held through the auspices of the professional bodies and non-governmental agencies most directly involved at the local level.

Outcome: A strengthening of understanding between adolescents, parents and service providers with regard to their respective roles in meeting the health needs of the young. Guidelines for the conduct of such fora.

9. Preparation for Parenthood

Problem: In many developing countries young people will have babies before they are sufficiently mature to rear them in a way which will ensure their healthy development. In few countries is there any overall provision for providing young people with the opportunity to learn what they can before becoming parents. There is an urgent need to provide such help to prevent damage to the young parents, the child, and to society itself.

Objective: The provision of preparation for responsible parenthood through educational programmes designed for them and culturally appropriate.

Methodology: The design of such a programme is dependent on the identification of a number of factors: a) how early is it appropriate and acceptable to prepare for family life - this will depend on the degree of sexual activity of adolescent boys and girls. Where it is early school programmes before the majority leave school are essential and the content may be more sophisticated. Where it is late a school programme may be followed by offering such course to those who become betrothed in a publicly identifiable way, b) Where can the population of young people most likely to become parents be found? Where most marry before childbirth registries offer a special opportunity; where, however, a large portion of young women, especially are at risk of parenthood outside of marriage other approaches are necessary - the workplace, e.g., family planning clinics, youth clubs, and through special media designed to reach the young. The tailoring of such programmes for parenthood must be done with the utmost cooperation of local authorities, and such a 'sensitisation' process is necessary before any attempt to implement a programme for parenthood is put into operation.

Outcome: A series of modules containing appropriate materials designed to meet diverse conditions in developing countries in order to optimize the relationships between young men and women and prepare them as parents of the next generation.

10. Multi-Centre Research

Problem: While the ultimate goal of the task force on RHA is to promote adolescent health, and the facilitation of action is often the most attractive route to that a research component is essential for virtually every project if it is to have a 'multiplier' effect and be used elsewhere or even in the same place again. As was noted in descriptions of interregional workshops time and again, the value of interacting with those who come from other societies with different views, with other sectors and with other age groups, has been proven as has danger of too parochial a view. There is a continuing need to foster such interaction and to extract the successful from the unsuccessful.

Objective: To promote multi-centre collaboration to assist the process of intersectoral interaction and identify for global dissemination successful components and strategies for adolescent health.

Methodology: A continuation of the collaboration with governments, NGO's and other agencies for research to provide sound technical support for action and research projects, disseminate the best methodologies and the findings to the widest possible appropriate audiences.

Outcome: Dissemination of the state of the art technology in adolescent reproductive health for developing countries. Full sets of guidelines and protocols for each theme.

11. A Clearing House for Adolescent Reproductive Health

Problem: While it is clear that there has been an acceleration of activities in this subject matter there is a considerable loss of information owing to: a) a great time lag between projects and their publication, b) the general absence of information about methods used rather than findings, c) the fact that much work outside of academic settings is never published, d) and the general absence of information about failures as opposed to success.

Objective: To establish a clearing house for information about a) current projects, b) project directors, c) methods and procedures employed, d) problems encountered, and e) new ideas.

Methodology: Through the auspices of an experienced body such as the International planned Parenthood Federation (IPPF) in collaboration with the WHO Task Force of RHA, a clearing house is to be established using the networks of both groups and that of other NGO's for the collection and dissemination of information. Emphasis will be placed on rapid processing using the most cost-effective means to enhance communication between investigators in the field and for international dissemination.

Outcome: Rapid dissemination of information about current activities in the RHA field to facilitate learning from erros, replication when it will be of value, and the stimulation of new thinking.

12. Publications

a) Problem: While there are many experts in each of the sectors which impinge on adolescent reproductive health, no one is an expert in all, nor is that necessary. However, it would be of great value if each service provider had a sound and practical understanding of the nature of the expertise that the adolescent might encounter in another sector.

Objective: A publication in lucid language and technically sound describing the nature of problems, manner of assessment, and forms of treatment in each of the main sectors dealing with adolescent health, including psychological, medical, social, educational and legal.

Methodology: Two to three consultants, each expert in different sectors noted for the clarity of their writing will form, together with WHO staff, a working group to outline the needed publication. This will, in addition to their own expertise, be based on research findings drawn directly from the young population identifying their own major anxieties and from information about the experience of service providers.

Outcome: A lucid guide to adolescent health for service providers from all sectors enabling them to have an overview of adolescent health needs and provision for them so that they can facilitate help to the adolescent population in their own societies.

b) Problem: Rapid evolution through the interregional, regional and national workshops of the grid methodology for adolescent reproductive health planning have made it desirable to update the guidelines in WHO offset 77 for action-oriented research.

Objective: Guidelines for the running of workshops utilizing the grid methodology, criteria questions, the system for prioritising action, and modules for use following the selection of action and/or research projects.

Methodology: Data from working group has already been collected and pooled with WHO experience to expand the system for health planning and guidelines for the running of workshops.

Outcome: An improvement in the autonomy of workshops at the national level using the grid approach, and facilitating communication within and between countries.

Implications for Country Policies and Programmes

The programme of action outlined above has as its ultimate objective the promotion of adolescent health at country level. To achieve this goal it is necessary to reduce barriers to the implementation of direct action which currently exist, as well as provide support to direct action where that is currently possible. The twelve point action plan proposed is designed to address both kinds of activity.

In the main, the workshops proposed and the supporting material necessary to run them are of the former kind. The action/research workshops have been used to assist country participants to focus on national needs and to identify alternative course of action from which the next step at country level may proceed. It has also, however, provided some training to the participants in formulating plans of research and action. It has become apparent that there is both a need and demand for the development of such skills so that systematic planning for adolescent health may take place. For this reason and to ensure a multiplier effect especially in developing countries, facilitator workshops are proposed. The aim of increasing autonomy at country level is also served by the development of microcomputer software for facilitating information dissemination in a systematic way, and the clearing house (to which it ultimately may be linked) for the purpose of providing information about projects rapidly and to the most relevant individuals and groups.

Two of the activities proposed, intermediate between the four activities above and support to direct action, are the counselling workshops and the multi-centre research empoloying the 'gatekeeper' design. Both of these have commonly been identified at the end of the workshop process as the next needed step at country level. The counselling workshops are designed to bring together those from each relevant sector, including in some cases young people themselves, to provide them with basic knowledge and skills necessary to interact successfully with adolescent in need of guidance, especially in relation to reproductive health questions. They are also, by their very nature, sensitizing activities which are designed to reduce anxiety about topics such as sexuality in the participants themselves to enable them to deal more effectively with the planning and provision of counselling services. The 'gatekeeper' design is another activity which has been identified as a necessary step in implementing action at the country level. This is also a sensitising process in which the key decision makers and activators in a given society are part of the initial research programme, enabling both qualitative and quantitative research on sensitive subjects to be carried out, and providing an automatic channel of feedback to these key people to facilitate direct action. The nature of the research which is fed back to them is of course specifically dependent on gaps in information and knowledge at the country level.

The types of research needs which do emerge are varied, but methodologies and guidelines for conducting such project have been and/are continuing to be developed through the Task Force on RHA. Many such designs and materials are now available for tailoring to country level needs, including baseline information on the characteristics of adolescent health problems, on health service research examining the interaction of health service providers with the clients they serve, on the outcome of pregnancy, on establishment of norms for menarche and 'spermarche' and designs for studying the newly married populations. For all such projects and others which emerge from the workshops planning, technical support is necessary at crucial points throughout the project.

In addition to research designs and back up materials, models for direction action have also been developed in the Task Force. For example, a design for utilizing adolescent participation in drama incorporating a 'voting' procedure for systematic live action/research has been developed. A plan for the institution of telephone counselling in an industrial area with special reference to the adolescent population is another. Such modules are continuing to be developed to fit emerging needs and form part of the implicit activities of the RHA programme staff.

In addition to the activities above which are designed to create the conditions for direct action by facilitating and promoting mechanisms, people, and material systematically, it is envisaged that further direct action support will emerge as the programme continues. Two types of such activities which have been proposed for systematic development at country level but with inputs from WHO and other relevant NGO's are: those seminar formats for the interaction of different sectors with adolescent groups, and for those which involve parents in similar procedures. There are special needs which are different at country level, and especially between urban and rural environments. Much of the experience of the RHA Task Force can be utilized in developing the formats for trial and evaluation, including the research findings which continually emerging from the programme. This applies as well to the activity designated

"preparation for parenthood". The precise state of the attitudes of key people in the cultural context of a given society will determine the starting point of such a programme. It is inevitably linked to the other activities of the proposed plan of action.

Two major activities related directly to young people themselves are anticipated as essential ingredients at country level of young people's participation. One is a form of 'consumer education' for the young so that the services of all kinds which are currently available are more likely to be utilized. To do this research of a special nature is necessary at the local level to provide a practical guide to young people's health needs and how they can go about obtaining appropriate help. While this is an element in the grid approach used in workshops, and specific project requiring technical support at the outset are necessary, it is to be hoped that such a resource will be sustained and regularly updated at the country level. Of great importance is the participation of young people at the local level in the planning and to an important extent the delivery of health and health related services both to their peers, and to other groups in society. Strengthening of the Task Force's relationship with youth council international and national NGO's and other youth groups is underway, and a major effort is anticipated to strengthen the health component in their resources.

Thus three of the activities proposed for support at country level are counselling, intersectoral seminars for the exchange and softening attitudes, forum for the interaction of young people with both those from the service providers of a community and with such representatives, and parents in the appropriate cultural context. To the extent feasible it is hoped that these activities will become part of national programmes designed to promote adolescent health and well being.

As an integral part of the proposed plan of action it is expected that there will be further development of modules incorporating wide variety of materials. They will include in addition to major publications, guidelines for research, project planning, and running of specialized workshops, microcomputer software, video materials for certain programmes, and a variety of technically sound materials directed to the diverse target populations identified in this proposal. In addition to an updating of WHO Offset 77 utilizing the grid approach for workshops and adolescent health planning, it is anticipated that a book will be produced for use in the field integrating technical information on adolescent reproductive health problems and treatment from different sectors, in lucid language with a section of key questions for the worker at local level. It is anticipated that much of the material outlined above will be produced with the help of country consultants, and the central springboard of the RHA Task Force will stimulate the production of material at the local level by country experts utilizing outside sources of funds.

Overview

The strength of the Task Force on RHA has been its capacity to draw on people from all regions, at different levels of influence and expertise, and from different sectors. It has from the outset closely collaborated with the IPPF and is currently strengthening collaboration with other NGO's involved with young people worldwide. The lessons learned from the programme are that it is essential to listen in a systematic way to those directly involved in the health of the young (including, not least, young people themselves), integrate such knowledge in ways which are both scientifically sound and imaginative, and strengthen the human resources to enable them to promote the health of the young. Nothing is more satisfying than experiencing the fulfillment of potential, nor more distressing than its frustration. The action proposed here is designed to reduce the barriers and enhance the opportunity for the healthy development of adolescents, so crucial to the immediate future of all societies.