Report of the Pre-Conference on Adolescent and Youth health in Prelude to the Second ECOWAS Forum on Good Health Practices

25 October 2016, Grand Bassam, Cote d'Ivoire

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Introduction

Organized by the West African Health Organization (WAHO) and the IBP (Implementing Best Practices Initiative), Adolescent and Youth Sexual and Reproductive Health (AYSRH) Task Team, the Preconference on Adolescent Health prior to the 2nd WAHO Good Practices Forum aimed to build a shared understanding of the nature and scale of select adolescent health priorities in West Africa, as well as evidenced-based approaches to address these priorities and strategies for their scale-up. The preconference was also a space to stimulate reflection and discussion on how the four themes of the Good Practices Forum[1] can contribute to strengthening national responses to adolescent health. The pre-conference was designed to give balanced time to informed situation analysis focusing on adolescent health and discussion of possible approaches to responding to priority problems in reaching and addressing adolescents through the exchange of experience between practitioners in each country setting. The preconference brought together roughly 90 participants, including representatives from the Ministry of Health of the 15 ECOWAS countries, local civil society organizations, young leaders, international NGOs, UN agencies, donors and WAHO staff.

Objectives

1. To build a shared understanding of:
    a. The nature and scale of selected adolescent health public health priorities in West Africa;
    b. Evidence based approaches to address them;
    c. Strategies for scaling-up these approaches.
2. To stimulate discussion on how the four themes of the Good Practices Forum contribute to strengthening country responses on adolescent health (institutional reform, strengthening human resources for health, employing health technologies and using evidence in policies and programs).

Expected outcomes

- A journal paper/commentary on the pre-conference
- Improved knowledge and understanding of the topics tabled and discussed
- A clear sense of how the new generation of adolescent health/ASRH program need to build on the lessons learned from the past
- Participants well prepared to use an adolescent lens in the WAHO forum
- Learn about scaling up tools and approaches

[1] The four themes are as follows: institutional reform, strengthening resources for health, employing health technologies and using evidence in policies and programs.

Opening Ceremony and Plenary

The pre-conference was opened by an official opening panel, including Dr. James Kiarie, Coordinator for the World Health Organization, (WHO) Human Reproductive Team, Dr. Francis Kateh, the Vice-Minister of Health of Liberia, Dr. Sheila Mensah, USAID West Africa Regional Office, Peggy d'Adamo, USAID Washington and Dr. Xavier Crespin, WAHO Director General.

Dr. James Kiarie, Program Coordinator for the WHO Human Reproductive Team and Representative of the IBP Initiative highlighted the functions of IBP as a unique international partnership initiated in 1999 by WHO, USAID, UNFPA and nine Cooperating Agencies, and dedicated to scaling up what works in family planning and other areas of reproductive health. Its vision and mission are to bring about improved reproductive health outcomes and contribute to achievement of FP2020 goals and the SDGs through mobilizing the global SRH community to identify, implement and scale-up effective practices and global guidelines through its convening power as a neutral platform for knowledge sharing and collaboration. With 45 partners and a secretariat made up of USAID, WHO, UNFPA, the IBP Initiative shares knowledge about what works in public health, promotes use of proven practices and fosters collaboration among organizations and governments to scale-up these practices. The IBP Initiative has four key working principles : a) Program interventions should be evidence-based and aligned with global guidelines; b) Don't reinvent the wheel: minimize duplication, maximize use of limited resources and harmonize approaches; c) Individual organizations will achieve more by working together; d) Foster equal participation for all members and encourage field engagement.

Dr. Francis Kateh, the Vice-Minister of Health of Liberia stressed that health interventions must reach each individual mother in every village to be truly effectively. Health interventions must also have benefits for youth and adolescents on a daily basis. He recommended that preconference participants keep this perspective in mind when discussing interventions and approaches to address reproductive health for youth.

Dr. Sheila Mensah of USAID's West Africa Regional Office in Accra, Ghana, thanked participants for making the health needs of adolescents and youth a priority. She noted that USAID supports WAHO in its efforts to scale up adolescent health programs, stating the pressing need to ensure access to reproductive health services for youth and the need to invest in young people's health and development, as they make up 60% of our communities. She recommended that advocacy and investment for scaling up high-impact practices for youth programs are especially important now that new funding is available. She stressed that when youth are healthy, communities are healthy and whole region is healthy.

Peggy D'Adamo, the representative of USAID Washington, DC, noted the strong collaboration between USAID and WHO, expressing strong support for the IBP initiative. She sees the initiative as a peer-to- peer communication platform that facilitates collaboration with other countries to improve individual country programs.

Dr. Xavier Crespin, Director General of WAHO, expressed delight at the turnout of participants. He encouraged all participants to support WAHO's 2016 - 2020 strategic plan and to use it as a tool to advance health priorities in the ECOWAS region. He noted that there is a growing body of evidence about

adolescents and youth health problems in the region, including unintended pregnancy, low contraceptive use, etc. He urged participants to use this information to promote good practices. He also noted that individual countries should advocate at the highest levels of government to scale-up good practices to allow a greater number of people to benefit from them. He stated the need for using competent human resources and appropriate technologies to develop concrete initiatives we can implement in the various West African countries, using the combined potential of all partners. He concluded by thanking the ministries of health of all the ECOWAS countries for their work, before declaring the preconference open.

Following the opening ceremony, two technical presentations shared an overview of adolescent health globally and in West Africa.

Dr. Matti Parry, WHO HQ, gave an overview of the current global context of adolescent and youth health. He briefly summarized the past 25 years of international work on adolescent and youth public health, beginning with the Convention on the Rights of the Child (1989), the International Conference on Population & Development (1994), and the setting of the Millennium Development Goals (2000). While overall achievements in health have been observed during this period - a 45% drop in maternal mortality and a reduction by 50% in under-5 mortality – progress has been much slower for the health of adolescents. For example, the adolescent pregnancy rate has not substantially decreased, with the number of children born to girls aged 15-19 years reducing only slightly from 64% to 56%. Four countries in the region are in the list of the top ten most fertile countries in the world. In addition, achievements in HIV prevention, treatment and care for adults have not been paralleled for adolescents.

Globally, the causes of mortality and morbidity among adolescents include: mental health issues, road traffic injuries, iron deficiency, HIV and AIDS, and self-harm. There is great variance between regions, with African regions having clear outliers. The West Africa region is higher than average on HIV, malaria and neglected tropical diseases, as well as maternal health complications. Dr Parry stressed that many sexual and reproductive health issues are not sufficiently reflected in morbidity and mortality measures in the region. He concluded by stating that being the region with the highest adolescent morbidity rates, there is now widespread recognition of the need to address adolescents.

Dr. Yves Mongbo, WAHO, shared a summary from the 2015 situational analysis on adolescent and youth health issues in West Africa undertaken by WAHO. The analysis informed the development of a guide for ECOWAS member states to assist in developing national strategies for adolescent health. Among the major findings were the following: an abortion rate of 26/1000; wide variance in STI prevalence among young women (6.6% in Nigeria as against 53.7% in Liberia); variance in early marriage (from 8.3% in Ghana to 59.1% in Niger); FGM rates in Guinea reaching 94%. Other adolescent and youth health risks not related to reproductive health are tobacco use, alcohol use, poor nutrition, violence and chronic anemia. Changes in behavior and lifestyle have led to multiple sexual partners without protection. Knowledge of family planning is high (80-90%), yet contraceptive prevalence rates remain low. There is good general knowledge of HIV prevention, but HIV prevention measures remain insufficient. The situational analysis concludes that investment in adolescent and youth health is a priority in order to capitalize on the demographic dividend. In order to do so most effectively, it is imperative to address the social determinants of adolescent health.

Youth representatives, Mea Olympio (AgirPF/EngenderHealth) and Dadja Masama (ATBEF), presented a role play that demonstrated some of the challenges that young people in the region face when trying to access sexual and reproductive health information and services. The play concluded with a call to action for all participants to ensure meaningful youth participation in decision-making about adolescent health and to further prioritize adolescent and youth health in national programs, policies and budgets.

First Working Session on Adolescent Health Priorities in West Africa

The first working session commenced with a series of presentations to set the stage about select adolescent health priorities in West Africa. This panel aimed to stimulate reflections for small group work that aimed to explore current responses to these issues in the different countries, as well as approaches for implementing and scaling up evidence-based practices.

Marie Soulie, UNFPA/WCARO, gave a presentation on early and unintended pregnancies, including contraception for prevention. She noted that, globally, 90% of adolescent births occur within marriages. In West and Central Africa, very low contraceptive prevalence rates and low access to education contribute to an adolescent pregnancy rate of 133‰. In comparison to other age groups, married adolescents or those in union have both the modern contraceptive prevalence rates and the highest levels of unmet need for contraception. Early pregnancy can derail a girl's healthy development and prevents her from achieving her full potential. Adolescent girls who become pregnant are significantly more likely to be poorer than their peers who haven't given birth and to have poorer nutritional and health status. Ms. Soulie stressed that, in the case of child marriage, consistent use of effective contraception is essential to prevent early pregnancies. UNFPA recommends the following evidence-based practices to reduce early and unintended pregnancies: delay the age of marriage until after age 18, increase consistent use of modern contraception among adolescents and youth, delay sexual initiation and reduce coerced sex. In addition, in order to reduce maternal mortality and morbidity among adolescents, it is important to reduce unsafe abortions and increase the use of skilled antenatal, childbirth and postpartum care by young mothers.

Dr. Blami Dao, Jhpiego, gave a brief presentation on mortality and morbidity during ante-, peri- and post-natal periods among adolescents. Disputes in the definition of the adolescent period (10-19) in the region make comparing data across regions and countries difficult. West Africa's high adolescent birth rates may be under-reported, due to failure to capture information about births among very young adolescents, less than 15 years of age, especially those who are forced to marry, and frequently prevented from going to school. This group is at the highest risk of pregnancy-related morbidity and mortality. While data suggest that the risk of mortality associated with adolescent pregnancy compared with pregnancy in women aged 20–24 years might not be as great as previously believed, Dr. Dao stressed that pregnancy-related complications are nevertheless an important health priority for adolescents in West Africa. The main causes of maternal morbidity among adolescents include pre-eclampsia, eclampsia, puerperal endometritis, caesarean-section, obstetric fistula, and post-natal depression. Referring to the WHO's 2011 Guidelines for Preventing Early Pregnancy and Poor Reproductive Health Outcomes in Adolescents, Dr. Dao highlighted the following strategic approaches to reduce maternal mortality and morbidity among adolescents: prevention of early marriage, prevention of early pregnancy, keeping girls in school,

comprehensive sexuality education, community-based economic and social support programs, increasing the use of contraception, including PPFP (post-partum family planning), reducing coerced sex, prevention of unsafe abortion, increasing access to quality prenatal care, childbirth, and postpartum care programs.

Dr. Isabelle Kouamei, UNAIDS – Cote d'Ivoire, spoke on HIV/AIDS and adolescents in West Africa. There are 4,810,000 people are living with HIV/AIDS in the ECOWAS region. Nigeria, Cote d'Ivoire and Togo have the largest number of cases, yet only 25% are currently using ARVs. ARV coverage is low and far from the 90% goal. Adolescent and youth HIV infection and prevalence rates are alarming suggesting a potential risk of returning to epidemic levels if nothing is done now. Nine out of ten children with HIV/AIDS are not receiving ARVs in West Africa. For those aged 10-19 years, there has been no significant reduction in HIV-related deaths. Comprehensive HIV/AIDs knowledge is low – less than 35% of adolescents (10 – 19 yrs.) have comprehensive knowledge about HIV. Of young people aged between 15-24 years, only 10% of young men and 15% of young women are aware of their HIV status. Prevalence is higher among females than males. Challenges that will need to be addressed in the ECOWAS region include: achieving global PMTCT (eMCT) goals, increasing pediatric HIV treatment, combined prevention strategies, including among youth, innovative financing, expanding voluntary HIV testing and counseling and ensuring adequate data collection and analysis.

Romaric Ouitona, FP Young Ambassador from Benin, then spoke in response to the presentations. He questioned why there was deterioration in adolescent health in the region and made the following recommendations:

- Create campaigns on adolescent health and HIV to generate more awareness. Find ways to effectively use peer-to-peer channels for share evidence-based information about sex and reproductive health.
- Break taboos surrounding discussions about sex in public settings and among families.
- Involve youth in the design of research on adolescent and youth behavior change.
- Find ways to make youth and adolescent centers more effective.
- Engage youth in activities that build leadership skills that will serve them in future.

Following the panel, participants divided into thematic groups by language. English and French language groups discussed either (1) early and unintended pregnancy among adolescents, as well as maternal mortality and morbidity among adolescents or (2) STIs, including HIV among adolescents. Each group discussed the state of response to the specific health issues in the different countries and the different policy and programmatic approaches for implementation and going to scale in order to address these health issues. The summary of these discussions is as follows:

Early and unintended pregnancy among adolescents, as well as maternal mortality and morbidity among adolescents

The groups generally recognized that the current operating context in West Africa regarding early pregnancy and maternal health for adolescents is limited by a lack of integrated responses, as well as

weak and inconsistent financing at national and regional levels. This leads to lack of access at the local level to health services for adolescents and youth. In addition, restrictive cultural barriers prevent youth from seeking services. While at the policy level early marriage, contraception and maternal health are being addressed, these policies do not often trickle down to individual districts, communities or service delivery points.

Country responses in the ECOWAS region vary widely. Some countries have made progress in translating policy into action at the state or district level. **Nigeria** created model Youth Friendly health centers, and guidelines for scaling up the adolescent and youth friendly services model. They have strong linkages with school programs and community health programs, including through peer-to-peer programs and teacher training in reproductive health. **Senegal** created a multi-sectoral platform for addressing adolescent and youth health issues, as well as behavior change communication channels for sharing reproductive health messaging. They are adding to the understanding of the drivers of undesired pregnancy and early marriage through field studies that add to evidence in the region. **Burkina Faso** is preparing to launch a major "Zero Pregnancy" campaign aimed at school-age girls, and an expansion of the "Husband schools" model piloted in Niger. **Benin** is expanding youth centers, linking them with leisure activities to attract more youth. **Ghana's** adolescent health program emphasizes male involvement and engagement to space births, while championing a liberalized abortion policy. **Togo** is working to increase the number of school nurses that are trained in reproductive health. The **Gambia** has free maternal health services, but continues to have low male acceptance rates for contraception and no youth orientation to its program. **Mali** has several youth-focused behavior change efforts ongoing, as well as a "Proud to be a woman" campaign that seeks to increase the self-esteem of girls to make decisions about their reproductive health. **Guinea** is integrating health and education programs, and seeking greater participation of youth associations. **Niger** is testing new approaches for young husbands' schools, a youth parliament and a collaborative framework for youth issues across sixteen ministries.

The working groups identified approaches to implement and scale-up good practices at different levels. At the **policy level**, participants discussed the possibility of creating a regional policy network for early marriage and reproductive health in ECOWAS countries. The groups agreed that greater participation of youth in policy advocacy and policy making at all levels would be welcome. Expanding the idea of youth parliaments, and young people's leadership programs would strengthen their voices with the decision makers at the national level. At more local levels, developing communication and advocacy programs aimed at community leaders and religious leaders, as well as adaptive approaches for communicating to segmented populations within communities would be useful. Overall, it was felt that a policy target in the short term should be to create consistent laws across the region limiting the minimum age of marriage to at least 18 (for girls and boys), and requiring religious institutions to verify proof of age before conducting marriages.

At the **health systems level**, it was agreed that there should be a core set of strategies for addressing the adolescents and youth health across all ECOWAS countries, and, where applicable, Adolescent and Youth Health Divisions should be created in all national ministries of health. Reproductive Health and early marriage are multi-sectoral issues, so there was strong support for the creation or strengthening of multi-sectoral platforms in each country to address adolescent and youth health in a more holistic way. The

critical role of youth associations was mentioned, including serving as liaisons between health services and young people.

From the perspective of **service delivery**, the groups agreed that offering free services (removal of user fees) would draw in more adolescents and youth. Access to sexual and reproductive health services could be further increased through task-sharing, mobile services and addressing provider bias. Integration of adolescent and youth health into non-health programs is of high importance as well.

At the **community level**, there is more need for community mobilization programs led by young leaders themselves to address adolescent pregnancy and early marriage. Intergenerational dialogue facilitated by community groups is a potentially powerful strategy. Community leaders and influencers should be targeted for their ability to spread credible messages to their communities.

Scaling-up **behavior change** interventions was a major focus of the discussions. Focusing on key influencers, including husbands, mothers-in-law, grandmothers and religious leaders can create social networks that channel evidence and rights-based information to adolescent girls and boys about sexual and reproductive health. Comprehensive sexuality education in schools can be supplemented with television or radio series, comic books or reading clubs that focus on reproductive-health related life-skills.

STIs, including HIV among adolescents

Participants highlighted that AIDS is the leading cause of death among adolescents (10-19) in Africa and the second leading cause of death among adolescents globally. The group also acknowledged the importance of addressing HIV and STIs in Nigeria, as it is one of the six countries (South Africa, Kenya, India, Mozambique and Tanzania) making up about half of the adolescents (15-19) living with HIV is globally.

In terms of the current state of the response, participants felt there is political will and recognition that STIs and HIV is a public health problem in the West African region. Most of these countries have policies and plans guiding intervention and programs to address the issue. Most of the ECOWAS countries are recipients of the Global Fund for Malaria, HIV/AIDs. Other donors are also present including USAID, CIDA, and AFD.

Currently, several evidence-based practices are being applied in various West African countries to address STIs and HIV among adolescents. In **Nigeria,** sexuality education and public campaigns to create awareness and promote safe sex, as well as community based interventions - using storytelling, games and popular theatre to increase knowledge of HIV and AIDS. Other practices included: the use of mobile phones to send SMS for counselling and referrals to facilities for STI and HIV related services; integration of HIV counseling and testing into routine antenatal care services for pregnant women (PMTCT), faith-based interventions to increase support from Christian and Muslim communities; and free counseling and STI treatment for young people in primary health facilities (Nigeria). The **Abidjan–Lagos Transport Corridor joint regional HIV/AIDS Project** was cited as an evidence-based project. It involves five countries (Cote d'Ivoire, Ghana, Togo, Benin and Nigeria) and achieved great results, including: increased knowledge of how to prevent HIV, more diagnosis and treatment of sexually transmitted infections (STIs), greater

condom availability and use, and greatly increased voluntary HIV counseling and testing. Different stakeholders in various locations benefited from the project truck drivers, sex workers, travelers, border communities, and military and customs officials.

The group identified the following opportunities to scale-up evidence-based practices.

To **create an enabling environment:**

- All the countries have existing policies and plans to guide HIV intervention programs. Some countries are reviewing policies to include SDG targets and other global initiatives. Most counties have an existing agency established to coordinate national and sub national response to HIV and AIDS
- Existence of anti-stigma and protection legislation for people living with HIV and AIDS
- Domestic funding and donor funding available, though not adequate. For example, **Nigeria** is one of the countries selected to benefit from round 1 of GFF. Efforts are underway to develop country level business case for GFF, which can include adolescent focused HIV and STI efforts.
- Existence of strong CSO groups advocating for scale-up of treatment

Recommendations to **strengthen programs:**

- Greater investment in PMTCT interventions, including with adolescent girls, to prevent new infections
- Regional interventions such as the Abidjan -Lagos corridor projects
- Integration of HIV /AIDS into the formal school curriculum at all levels of education (Middle, High and College level)
- Use of technology and media for public education and awareness campaigns

Second Working Session on harmful practices for adolescent health

The second working session was led by a panel of three speakers that presented on various harmful practices to adolescent health in West Africa.

Theresa Kaka Effa, Public Health Institute, presented on gender-based violence in adolescents. Gender-based violence is widespread globally and in West Africa. 30% of women globally have experienced physical and/or sexual violence by an intimate partner, including physical/sexual/emotional abuse, conflict relate drape, honor killing, female genital mutilation, trafficking, and forced and early marriages. One out of five Nigerian women aged 15-24 years has been a victim of at least one form of violence. 29% of Beninese women aged 15 – 19 are in forced marriages and child prostitution is rife. 75% of Gambian and 94% Guinean women and girls have experienced FGM. Female trafficking is widespread in Cote d'Ivoire. In Liberia child rape is believed to increase a man's power and virility. Women from 10 to 18 years old in Ghana are most at risk of sexual violence compared to older women, especially incest.

The intergenerational health and socio-economic effects of sexual violence include higher rates of infant mortality and mortality, physical injury, behavioral problems, anxiety, depression, suicide, poor school

performance and increased likelihood of perpetrating violence as adults. Adolescent survivors of gender-based violence have higher rates of STI/HIV infection, teenage pregnancy, low self-esteem, substance abuse. Approaches to address GBV include advocacy to promote women's access to employment & microcredit, education and legal assistance ; in & out of school interventions for boys and girls to change gender narratives ; legislation prohibiting violence against women ; gender equality in marriage and property laws ; Youth-friendly services to increase access to contraceptives and FP services; emergency health and other services for survivors of GBV ; social and behavior change communication programs that involve community &religious gate keepers.

Current gaps in addressing GBV are weak implementation or enforcement of existing policies and laws, as well as cultural and religious norms. There is a dearth of data due to culture of silence and low reporting rates. Also, the insufficient evaluation of GBV interventions makes it difficult to ascertain effectiveness and scale up of best practices.

Dr. Lydia Saloucou, Pathfinder International, spoke on the prevalence of early marriage of adolescents. Early marriages have been common in West Africa for a long time. Out of the 15 countries with the highest rates of child marriage in the world, six are in the ECOWAS region[2]. While some countries have made progress in reducing early marriage, other countries have stagnated or trended towards earlier age of marriage. Child marriage rates are very closely linked to household wealth throughout the region, with the poorest households having the highest rates of child marriage. Low education rates may drive child marriage, limiting families' economic options for girl children, and result in termination of schooling following marriage. Child marriage is typically higher in rural areas. Also, greater retention of traditional norms, narrow life options, stronger community networks, lower educational opportunities, and greater levels of poverty encourage child marriage. The association of these factors to marriage is complex and varies by girl, community, country.

Retaining girls in school is a key intervention to limit early marriage. School voucher programs, school uniform provision, school fee waivers can help to reduce the proportion of adolescents who marry. Life-skills curricula can also contribute to reductions in the proportion of adolescents who marry. Conditional and unconditional cash transfers can to reduce the proportion of adolescents who marry and increase the age of marriage. There is global recognition that such consequences demand concerted effort and strengthened commitments to end child, early and forced marriage.

Dr. Matti Parry, WHO HQ, spoke on female genital mutilation, defining it as a harmful traditional practice that includes all procedures that involve partial or total removal of the external female genitalia, or other injury to the female genital organs for non-medical reasons. FGM is practiced in more than 30 countries, with 200 million girls and women affected, most often on girls aged from 5 to 14, without their consent. FGM is associated with a range of health consequences in the short- and long-term. With no medical justification, FGM is driven by deep-rooted cultural norms about women's sexuality and gender roles. Social pressure, fear of social exclusion, perceptions of better hygiene, belief of increased "marriageability" are reasons given for this human rights-violating rite of passage to adulthood.

[2] Niger (76%), Mali (52%), Guinea and Burkina Faso (52%), Nigeria (43%) and Sierra Leone (39%)

There is only weak evidence about community interventions that can change attitudes to shift away from the practice. UNFPA and UNICEF are working jointly in 17 countries to accelerate the abandonment of female genital mutilation. WHO is developing clinical and policy guidelines to prevent and manage health complications of FGM. Evidence-based practical tools are needed for the health sector to support countries to implement guidelines and to respond to health aspects of FGM.

FGM practitioners include traditional circumcisers and birth attendants, as well as trained health-care providers like medical doctors, nurses, midwives, against WHO's opposition to the medicalization of FGM. Approaches to addressing the problem include surgical procedures for obstetric and urologic complications; psychological support, and information and education regarding FGM for women and health care providers.

Following the panel, participants split into thematic groups by language. English and French groups discussed: (1) Child marriage, (2) Gender-based violence and (3) FGM. The following is a summary of the information discussed in small groups to respond to the topic of harmful practices for adolescent health.

The groups saw some wide differences in responding to child marriage, FGM and other forms of GBV. **Nigeria** has robust federal policies on FGM and SGBV, as well as guidelines and manuals on how to address them at the local level. The Nigerian government is rolling out awareness raising programs through local media to encourage reporting cases of SGBV, and is carrying out research into the drivers of FGM. In **Togo**, the Ministry of Social Action carried out trainings of trainers on gender equality for health providers, including SGBV among adolescents and youth. **Ghana** is currently implementing a "Zero Tolerance" program for SGBV, seeking to rigorously apply the existing law, as well as seeking public and private partnerships to change behaviors and attitudes. **Senegal** has established a national committee to address the problem of violence against women. Supported by an active women lawyers' association, it is experimenting with "human rights boutiques" for victims of violence and abuse to inform them of their right to protection. **Sierra Leone** has developed a special police unit to deal with SGBV-related crime, and has established free legal aid for survivors within its Ministry of Gender. With a gender advisor for the President, **Cote d'Ivoire** has moved quickly with an anti-FGM law and procedures for management of SGBV survivors' cases, both medically and legally. The Cote d'Ivoire government is training police about how to handle SGBV cases appropriately, and has established annual weeks of activism against SGBV. **Liberia** has passed a law against rape, and has fast-tracked a law against SGBV in general. It has an active women lawyers group that has worked with the police unit established to address SGBV. **Cape Verde** has a gender studies institute that conducts research of SGVB, and offers specific management of adolescent and youth cases. **Burkina Faso** has been very active in social mobilization against sexual violence, and has recently completed a framework for legal assistance for SGBV survivors, and has conducted 16 days of activism to disseminate information about SGBV within the country. **Mali** has adopted a program to use community health workers to conduct behavior change strategies aimed at changing discriminatory social norms that lead to SGBV and FGM. **Benin** is rolling out multi-sectoral centers to address SGBV. **Liberia** passed a domestic violence act at the national level that covers early marriage and FGM.

The approaches currently applied to address harmful practices in the region or those that are currently under consideration by governments include: At the **policy level**, advocacy campaigns including "Zero

Tolerance for violence" campaigns and a toll-free help line campaign, help to increase access to information about services for survivors, while also raising awareness among leaders and legislators about the cost of FGM and SGBV to their countries. UNESCO has been supporting the roll-out of primary school programs that include teaching about gender norms, interpersonal relationships and gender-based violence. The establishment of protection units in schools could serve as a deterrent to gender-based violence. Changes in approaches to SGBV, such as targeting perpetrators of violence, instead of only working with survivors, and informing survivors of their right to assistance, both medical and legal, are important modifications to traditional methods of response. Integration of GBV and FGM information and communication into all areas of health and other sectoral activities will ensure that cases come to the attention of service providers, and are not covered up. The establishment of family mediation for families that are thinking of marrying their young girls out is an avenue to follow to change the practice, as well.

Third Session on Knowledge Transfer and the Use of Evidence to promote Adolescent Health in Policies and Programs

The subject of the final session was how the better transfer knowledge and the use of data for the promotion of adolescent health through policies and programs. The session started with two presentations on available evidence-based tools to inform programmatic decision-making.

Erin Portillo, JHU-CCP, shared a presentation about the HC3 project's tools that help practitioners implement social behavior change communication (SBCC) strategies for adolescents and young people, including in West Africa. Their approach to SBCC is holistic centered on the motivations and social characteristics of adolescents and youth. HC3 developed a toolkit to facilitate how to gain an understanding of such motivators and characteristics and how to use this understanding to develop messaging for adolescents on reproductive health themes.

- The "Urban Adolescent SRH SBCC I-Kit" provides guidance on how to conduct simple segmentation of target populations, looking at age, behavior and social situation.
- The LARC-Youth tools consist of posters and other ready-to-use resources that aim to increase youth access to all contraceptive methods, including long-acting reversible contraception (LARC).
- "Super Go" is an HIV-focused campaign in Cote d'Ivoire that included a set of four videos and discussion guides addressing how to protect oneself against HIV/AIDS.

Asa Cuzin-Kihl, IBP/WHO, presented IBP/WHO guides for scaling-up best practices reproductive health, including for adolescents and youth. The guides included:

- "Beginning with the End in Mind", which lays out a methodology for putting scale-up into project design from the beginning instead of waiting for the end of an intervention. This helps to increase the potential for sustainable scale-up of effective health innovations.
- "9 Steps for Developing a Scale-up Strategy" is a guide that explains how to plan and manage a scale-up strategy using 9 steps, which can lead to effective and sustainable scale-up of health innovations.

- The new “Guide for validating, sharing and documenting a best practice”, outlines the process of evidence consolidation that takes a practice from being “promising” to an evidence-based “best practice” in health programs.

Taking the queue from the presentations, workshop participants discussed in plenary how to improve knowledge transfer and the use of evidence for the promotion of adolescent health in the region. The following conclusions emerged throughout the discussion:

- There is insufficient research about adolescent health in West Africa, partly due to the lack of age-disaggregated health data. There is also insufficient data about effective practices for addressing adolescent health in West Africa.

- There is insufficient youth participation in program design and strategic decision-making. The problems facing youth are not all health, but multi-sectoral. Youth themselves know this well, and if they were included as partners in program design they could better channel this knowledge into effective programs.

- New technologies offer opportunities to reach larger numbers of young people in innovative ways.

- Adolescent Health interventions are currently lacking sufficient attention to human rights-based principles and language.

- Emergency contraception is an important contraceptive method for youth, as it can align with their needs and situations.

- We must invest in effective implementation of adolescent health innovations and interventions before we move to the evaluation stage.

- For one of the youths in the group it is important to hold oneself accountable “So that others take us seriously, we have to take ourselves seriously first”

- There are still major gaps in domestic resources for adolescent health in the ECOWAS region.

- The ECOWAS region has not yet developed an effective culture of monitoring, evaluation, learning, documentation and sharing of evidence on what works to improve adolescent health.

Recommendations

These conclusions led to the following recommendations:

1. WAHO should provide guidance to member states in order to strengthen national health information systems by including age-disaggregated data. WAHO should also recommend a set of harmonized adolescent health indicators that all ECOWAS countries could use to collect comparable health data.

2. Greater investment in research should be made in the region to inform adolescent health policies and programs. This includes investing in rigorous evaluation of promising practices and finding mechanisms to share existing evidence on proven practices.
3. There are a number of proven practices for improving adolescent health. The focus should shift towards scaling-up such practices, in order to reach a larger number of young people in a sustainable manner, while ensuring adequate adaptation to local contexts.
4. Young people should be meaningfully involved in all stages of policy and program processes. For example, young people should be central to the organization of future WAHO Good Practice fora and other such events.
5. New technologies (that youth are more familiar with than older people) should be used to reach out to larger numbers of young people. Every intervention that targets youth must understand the youth's world and connect with them in it.
6. Multisectoral approaches are essential to respond to the health needs of adolescents in a holistic manner. Health is but one aspect of youth development and health outcomes can be improved through integrated interventions in other sectors, including education, employment and women's empowerment.
7. It is important to strengthen country leadership to champion adolescent health, especially by ministries of health in the region.
8. Increased investment of domestic resources is important to advance adolescent health in the region
9. Donors should insist on the evidence that underpins every intervention, and to not accept the scale-up of new ideas without evidence of their efficacy. They must also recognize that there is great potential in local organizations. An idea that might be developed is to create a common funding basket for local organizations' activities.
10. Besides innovation, donors should also support activities that are already proven with substantial evidence of efficacy. We should concentrate on scaling-up interventions that we are sure will work, like girls' education. For these activities, we need to pass from « No Action, Talk Only (NATO) » to « More Action, Less Talk (MALT) »
11. WAHO should develop a central depository for research in the region and should consider publishing a regular bulletin of research, both planned and achieved to disseminate findings in the region.
12. Mechanisms to improve communication between researchers, decision-makers, youth and other stakeholders should be developed at a regional and national level.

Closing Panel

The pre-conference ended with a closing panel, where representatives of USAID, WAHO, youth participants and countries shared the final reflections about how to further advance adolescent health through good practices in the ECOWAS region.

It is clear that adolescents and youth are an extremely important segment of the region's population. They need the assistance of government to find their own solutions to health issues that they face. It is

important to realize that there is still much work to do. Commitments were made to increase youth participation for future WAHO events, including the Good Practices Forum. Commitments were also made to share the conclusions of the pre-conference with the main Forum and put into action going forward.

Annex 1. Pre-conference Agenda (25 October, 2016)

Time	Session Description
9.00 – 10.00	**Opening plenary** Opening ceremony • IBP/WHO • USAID • WAHO Director General Presentations on the key health issues : • Overview of AYH in the region (WHO) • Key health issues from the situational analysis on AYH (WAHO) Two youth speakers
10.00 – 10.30	**Tea/Coffee break**
10.30 to 12.15	**First working session on adolescent health priorities in West Africa** Presentations: 1. Early and unintended pregnancy, including use of contraception to prevent early and unintended pregnancies (UNFPA) 2. Mortality and morbidity during the antenatal period, delivery and the postnatal period (JHPIEGO) 3. HIV and adolescents (UNAIDS) 4. Commentary by a young person Small group discussion: • Current state of response in the countries of the region • Approaches used for implementing and scaling up evidence-based practices to address these issues; what has worked well, challenges.
12.15 – 13.45	**Lunch break**
13:45 – 15.15	**Second working session on harmful practices for adolescent health** Presentations: 1. Gender-based violence (PHI) 2. Child marriage (Pathfinder) 3. Female Genital Mutilation (WHO) 4. Commentary by a young person Small group discussion: • Current state of response in the countries of the region • Approaches used for implementing and scaling up evidence-based practices to address these issues; what has worked well, challenges. • Each group will be asked to use post-it notes to highlight key discussion points and post them on the wall.
15.15 to 15.30	**Coffee Break**

15.30 – 16.45	**Third working session on Knowledge Transfer and the Use of Evidence to Promote Adolescent Health in Policies and Programs** <u>Presentations:</u> 1. Brief presentation on SBCC tools for reducing early and unintended pregnancy (JHU-CCP) 2. Brief presentation on tools/approaches for scaling-up (IBP) <u>Small group discussion:</u> • Opportunities to foster knowledge translation and the application of evidence to strengthen policies, strategies and programs related to adolescent health • National commitments, policies and reforms they can prioritize to support adolescent health programming (including through national FP costed implementation plans and the development of national RMNCHA programs) • How to best use the opportunities created by new global and regional initiatives (ex. the Global Financing Facility in support of Every Woman Every Child, the Sahel Women's Empowerment and Demographic Dividend initiative, etc.) to scale up programming to improve the situation related to the three topics. • Identify next steps on how this can be achieved
16.45 – 17.30	**Closing plenary** • WAHO • IBP • Youth Participant

Annex 2. Participant List

COUNTRY	NAME
BENIN	Dr Ahissou Robert Franck ZANNOU, Directeur de la Sante de la Mère et de l'Enfant Dr TOSSOU-BOCO Thierry, C/SMI Dr AHOUNOU Gaston
	Dr BOKOSSA Alexis, Directeur de la Formation continue et de la Recherche, MS
	M ZOUNON Josué, Secrétariat Général du MS
BURKINA FASO	Dr Salifou KONFE, Directeur Général de la Santé
BURKINA FASO	Mme SOURABIE Angèle, ABBEF
CABO VERDE	Dra. Belmira Miranda, Ministère de la Santé
COTE D'IVOIRE	Dr OUREGA-LOBA Marie-Paula, Directeur Santé Adolescent, Jeune
	Dr DJAH Armand Josue, Président Réseau Jeunesse en Population et Développement
GHANA	Dr Ebenezer Appiah Denkyira, Director General Ghana Health Service
	Gifty Francisca Ben-Aryee, Head of Adolescent Health Unit Ghana Health Service
	Irene Amponsah Siaw, Planned Parenthood Association of Ghana
THE GAMBIA	Dr. Momodou Lamin WAGGEH, Director of Health Services
GUINEE	Dr. Feridah MARA, Chef Section Sant Adolescents et Jeunes
GUINEE	SANOH Fassouma, Directeur Exécutif AGBEF
GUINEA BISSAU	Dr Nicaolau Quintino Almeida, Director Geral da Prevenção e Promoção da Saúde
	Alfredo Claudino ALVES, Director da Saúde Reproductiva

	Mme Maximiana Maria Monteiro de Mendonca, AGUIBEF
LIBERIA	Dr. Francis N. KATEH, Deputy Minister for Health Services
	Mrs. Mandain JALLAH, Child Health Coordinator
MALI	Dr KEITA Fadima TALL, Responsable SAJ
NIGER	Dr Ibrahim SOULEY, Directeur Général
	Dr Halima MOUMOUNI, ResponsableSAJ
	Dr Ibrahima Boubacar, ANBEF
NIGERIA	Dr. Kayode A. Afolabi, Manager of RH FP
	Dr. Christopher C. Ugboko, National Manager of Youth and Adolescent Health and Elderl
	Dr Chinyere Okeke, University of Nigeria Teaching Hospital Enugu
SENEGAL	Dr BUABEY Marie-Jésus, Chargée de la SAJ
SIERRA LEONE	Haja Rugiatu Kanu, Child Health and Adolescent
TOGO	Dr DETI Kossi, Chef Division SAJ
PARTNER INSTITUTION	**NAME**
IBP SECRETARIAT	Asa CUZIN
	Ados VELEZ MAY
CARE/SIERRA LEONE	Alfred MAKAVORE
CARE/BENIN	Ghislaine ALINSATO
University of Jos	Innocent AO Ujah
Jhpiego	Anne Pfitzer
USAID/WA	Sheila Mensah
	Susan Mathew
Population Council	Nafissatou Diop
	Fatou Bintou Mbow
IRSS, Burkina Faso	Boukare Doulougou
WHO	James Kiarie
	Matti Parry
Université de Ouagadougou	Georges Guiella, Ph.D.

Action Health Incorporated	Adenike O. Esiet
University of Kinshasa	Patrick Kayembe
USAID	Peggy D'Adamo
Pathfinder International Senegal	Katie Chau
Pathfinder International (Burkina Faso)	Lydia Saloucou
Pathfinder International (Burkina Faso)	Bruno Ki
Pathfinder International	Sarat Konate
Pathfinder International (HQ)	Stephen Redding
Jhpiego	Willy Shasha
	Blami Dao
	Nancy Ali,
	Karine Nankam,
AgirPF	Rouguiatou Diallo, Chief of Party
Engenderhealth	Andre Koalaga,
	Martin Laourou,
	Eloi Amegan
	Cyrille Guede,
	Mea Olympio
	DADJA Massama, MAJ-ATBEF
	Assoumane Guero Issoufou
	Oscar Koalga
	Daniel Sébène
	Anoh Georges
	Eliane M. Dogore
Public Health Institute, Nigeria	Theresa Kaka Effa
Public Health Institute, Liberia	Kula V. Fofana
Public Health Institute, Ghana	Esther Azasi

USAID	Teshome Woldemedhin,
MSI Mali	Tiguida Sissoko
UNAIDS Cote d'Ivoire	Isabelle Kouame
Equilibres et Population	Aurelie Gal-Regniez
JHU-CCP	Erin Portillo
Medecins du Monde	Cecile Yougbare
	Elise Petitpas
Jeune Ambassadeur PF Benin	Romaric OUITONA
Réseau National de la Jeunesse en Population et Développement de Côte d'Ivoire	DJAH Armand Josue
IDRC/CRDI	Sue Godt
UNFPA	Marie Soulie
OOAS/WAHO	Laurent ASSOGBA
	Kofi BUSIA
	Gilles BOKPE
	Namoudou KEITA
	Aissa BOUWAYE
	Clétus ADOHINZIN
	Issiaka SOMBIE
	Yves MONGBO
	Clémentine SORHO-SILUE
	Lalaissa AMOUKOU
	Aruna FALLAH
	Mohamady ZONGO
	Albert K. OUEDRAOGO
	Lambert BOTON
	Clémence SANOU SOMDA
	Harvey Kosigah DE HARDT-KAFFILS

	Hadijatou JANNEH
	Fadima BA
	Albert Diao

Annex 3. Workshop Evaluation

Summary of quantitative questions

Total number of responses: 53

Question	Yes	No	NA*
First Time?	28	22	3

	Quotes						
	1 Strongly disagree	2 Disagree	3 No opinion	4 Agree	5 Strongly agree	NA*	Total
Q2: General Interest	2			25	26	1	53
Q3: Met expectations	2		4	32	15		53
Q4: workshop meetings		1	13	34	5		53
Q5: Would you recommend?	2		2	29	20		53
Q6: Facilitators were helpful?	1		2	36	13	1	53
Total	7	1	21	156	79	2	

*No response

What are your suggestions to improve the pre- conference?

Many of the suggestions for improvement aimed at better logistics and preparation. Participants suggested that the conference organizers mail the workshop agenda and objectives to participants well before the conference, with translation in Portuguese as well as French and English. They suggested that country participants be given homework to produce before the conference, like reinvestment plans, and be prepared to present them for discussion and consideration.

Better workshop room arrangements were requested, with better simultaneous translation services. Hotel and travel arrangements were cited and needing more organization.

There was an almost universal lack of adequate time felt, for presentations, group work and questions/answer sessions. Some even suggested that an extra day be planned. There was a felt need for plenary report-backs from the group work. Recommendations emerged around focusing on a specific topic, and requiring more concrete action planning by country.

There was a felt need for more evidence sharing among the participants to make the pre-conference more of a capacity building opportunity. The expectation of innovation was not entirely satisfied, and suggestions were made that there be more of an emphasis on new ideas.

There was a suggestion to taking more of a mapping approach in the sessions so that the small groups could understand better what was happening in each country. This would allow the small groups to better

focus on improvements or adaptations to make. It was suggested that the next sessions include a dialogue on key gaps and opportunities/windows of opportunity to advance AYSRH.

The universal felt need in the area of participation was that there be more youth representation in the pre-conference. It was even suggested that youth be tasked with organizing the next pre-conference. There was also a felt need to have more members of the governments of the member countries involved.

What did you find the most and the least useful?

Most useful

The majority of comments on the most useful part of the pre-conference are in the category of appreciation of the experience exchange that happened in the small groups. This allowed participants to hear about issues like early marriage from different perspectives, and gave them a chance to hear about other ideas and ways of handling issues in other countries.

There was strong appreciation of the role that youth representatives played in the plenary sessions and in small groups. The testimony of youth about their situations, and the sharing of their unique perspectives on how to help them with problem in reproductive health was illuminating for the participants.

There was a call-out of appreciation for the Vice-Minister of Health of Liberia, who spoke eloquently on FGM, as well as recognition of the diversity of the participants, coming from civil society, government and international partners and donors.

The presentations from subject matter experts analyzing the situation of various health themes set the stage well for the small group discussions, giving a sense of larger context in which these health issues sit, both regionally and globally. Documentation provided by the pre-conference was useful, as well.

Least Useful

Areas for improvement include the lack of report-backs from the small groups, the length of the opening ceremony speeches, and the relative absence of youth from the conference. There was a feeling that the work of the conference could have been more focused, and directed toward concrete outputs. Time management was also noted as an issue.

After this conference what will you share of the information with your colleagues in your countries?

A large part of the conference takeaway is in the form of renewed energy and dedication to making progress in the region. The need for more evidence based interventions was noted, as well as approaches to scaling them up to country context. Participants leave with a more holistic understanding of the place of youth in society and their problems with reproductive health, and the need to work across sectors to make progress. They signal that reproductive health is a team effort involving all partners, within a

regional context of sharing information on what works. Documentation is key, and the need for more documentation of different countries' experience is essential for helping countries decide what the best interventions for their countries are.

Other comments and suggestions

Aside from logistical issues to be resolved, the participants spoke of adding other themes, like mental and psychosocial health, to the agenda. They also expressed a desire to continue the discussions in other forums and to follow-up on the momentum of this forum.

Annex 4. List of Resources shared with participants

The IBP AYSRH Task Team prepared and distributed a folder of supporting materials to all participants. These resources and presentations can be found in the community of practice Knowledge Gateway Library. https://knowledge-gateway.org/global/ibpmembers/aysrhtaskteam/adolescenthealthwaho/library

The email address to participate in the COP is: adolescenthealthwaho@knowledge-gateway.org

High Impact Practices

- **Family Planning High Impact Practice List**
  https://www.fphighimpactpractices.org/sites/fphips/files/hiplist_eng.pdf (English)
  https://www.fphighimpactpractices.org/sites/fphips/files/hip_list_fre.pdf (French)
  https://www.fphighimpactpractices.org/sites/fphips/files/hip_list_por.pdf (Portuguese)
- **Adolescent-Friendly Contraceptive Services: Mainstreaming Adolescent-Friendly Elements Into Existing Contraceptive Services**
  https://www.fphighimpactpractices.org/afcs
- **Improving Sexual and Reproductive Health of Young People: A Strategic Planning Guide**
  https://www.fphighimpactpractices.org/sites/fphips/files/asrh_strategic_planning_tool.pdf
- **Educating Girls: Creating a foundation for positive sexual and reproductive health**
  http://www.fphighimpactpractices.org/resources/educating-girls (English)
  https://www.fphighimpactpractices.org/sites/fphips/files/hip_girls_education_fre.pdf (French)

Other Resources

- **IBP AYSRH Task Team Terms of Reference**
  https://knowledge-gateway.org/global/ibpmembers/aysrhtaskteam/adolescenthealthwaho/library/x325w8mf?o=lc
- **Tools for programs and services for adolescents and youth**
  https://knowledge-gateway.org/global/ibpmembers/aysrhtaskteam/adolescenthealthwaho/library/x325w8mf?o=lc

Websites

WAHO: http://www.wahooas.org/index2.php?lang=fr **IBP Initiative:** www.ibpinitiative.org

Knowledge Gateway: www.knowledge-gateway.org

Community of Practice at the Knowledge Gateway:

https://knowledge-gateway.org/global/ibpmembers/aysrhtaskteam/adolescenthealthwaho/library

High Impact Practices: www.FPhighimpactpractices.org **WHO/RHR:** www.who.int/reproductivehealth