

# REGIONAL GUIDANCE

## STRENGTHENING COMPETENCY-BASED EDUCATION ON ADOLESCENT HEALTH IN PRE- AND IN-SERVICE TRAINING FOR HEALTH-CARE PROVIDERS

EAST AND SOUTHERN AFRICA REGION





© Front cover photo: UNFPA ESARO/Chiara Frisone  
© Inside cover photo: UNFPA ESARO/Corrie Butler

# Contents

<b>ACKNOWLEDGEMENTS</b>	<b>1</b>
<b>ACRONYMS AND ABBREVIATIONS</b>	<b>2</b>
<b>DEFINITIONS OF KEY TERMS AND CONCEPTS</b>	<b>3</b>
<b>EXECUTIVE SUMMARY</b>	<b>4</b>
<b>PART 1. INTRODUCTION</b>	<b>5</b>
1.1. Background and Context	5
1.2. Rationale for the Regional Guidance	6
1.3. Process for Developing the Guidance	8
<b>PART 2. STRATEGIC FRAMEWORK</b>	<b>10</b>
<b>PART 3. GUIDING PRINCIPLES</b>	<b>11</b>
<b>PART 4. PRIORITY AREAS</b>	<b>12</b>
4.1. Support Leadership, Management and Accountability to Ensure that the Necessary Changes Take Place in a Sustainable and Integrated Way	13
4.1.1. Map key stakeholders	13
4.1.2. Identify and collate relevant policies, guidelines and strategic plans; and foster multisectoral and multi-stakeholder collaboration and coordination	13
4.1.3. Strengthen strategic information and capacity for advocacy and support for a stronger adolescent health component in pre- and in-service training	14
4.2. Develop Content and Strategies for HCP Training Programmes that Would Strengthen Core Competencies to Better Respond to the Health Needs of Adolescents	15
4.2.1. Carry out an adolescent health-focused content analysis of existing pre- and in-service training materials/ programmes for HCPs	15
4.2.2. Identify, adapt and develop core competency based curricula content and materials for priority health problems, provide examples of appropriate learning methodologies and identify potential trainers	16
4.2.3. Adapt and develop training materials for different HCPs that would strengthen their knowledge, skills, attitudes and behaviours to respond more effectively to the health needs of adolescents and youth	17
4.3. Develop and Implement a Plan to Strengthen the Adolescent Health Content of HCP Training, Through Existing Pre- and In-Service Training Programmes	18
4.3.1. Assess opportunities presented by different pre-and in-service training programmes, both those that focus explicitly on adolescent health and those that focus on health problems of importance during the adolescent years	18
4.3.2. Outline ways to integrate new and updated materials and curricula into existing certification and accreditation processes	19
4.3.3. Develop an Action Plan and identify key resources to support its implementation	20
<b>PART 5. CROSS-CUTTING THEMES</b>	<b>21</b>
5.1. Monitoring, Evaluation and Learning	21
5.1.1. Develop a framework for monitoring and evaluation	21
5.1.2. Develop systems to certify trainers and track HCPs who are trained in adolescent health CBE	22
5.1.3. Develop and implement quality assurance and quality improvement mechanisms for adolescent health training programmes	22
5.2. Engage adolescents and young people meaningfully in the process of strengthening adolescent health in training programmes for health-care providers	23

# Contents

<b>ANNEX 1. TOOLS, CHECKLISTS AND GUIDING QUESTIONNAIRES FOR SITUATION ANALYSIS</b>	<b>24</b>
1.1. Matrix and Questionnaire to assist the mapping of key stakeholders	24
1.2. Questions to support the identification and assessment of key stakeholders	24
1.3. Questions to help clarify the structure of adolescent health responsibilities within the Ministry of Health and other sectors	25
1.4. Questions to support the review of adolescent health training for HCPs	25
1.5. Questions to support the review of training programmes and materials for competency based education on adolescent health in pre- and in-service training, and CPD	25
1.6. Questions to support the development of an action plan for strengthening adolescent health in training programmes	25
1.7. Developing CBE on adolescent health for HCPs	26
1.8. EuTEACH modules	27
<b>ANNEX 2. PROMISING PRACTICES</b>	<b>28</b>
2.1. Strengthening coordination and collaboration: the Society for Adolescent Health, Uganda	28
2.2. Promising Practices: Youth-Driven AYFHS Involvement, evidence from the LINK UP Project AND P2Z	29
<b>REFERENCES</b>	<b>30-31</b>

# Acknowledgements

© UNFPA ESARO/Chiara Frisone



The United Nations Population Fund East and Southern Africa Regional Office (UNFPA ESARO) commissioned the development of this guidance. It was made possible with the technical oversight of Dr. Asha Mohamud, retired ASRH Policy Advisor at UNFPA ESARO and Ms. Maja Hansen, Regional Adolescent and Youth Specialist at UNFPA ESARO and the support of Ms. Renata Tallarico, SYP Regional Coordinator, Ms. Maria Bakaroudis, CSE Specialist at UNFPA ESARO and Ms. Tlangelani Shilubane, Assistant Representative, UNFPA South Africa.

UNFPA ESARO acknowledges the substantive contribution of Dr. Vitalis Goodwell Chipfakacha (SADC), Mr. Innocent Makwiramiti (COMESA), Dr. Michael Katende and Dr. Rogers Ayiko (EAC), Dr. Valentina Baltag and Dr. Mbola Mbassi Symplice (WHO), Ms. Anurita Bains and Mr. Renato Pinto (UNICEF ESARO), Ms. Patricia Machawira and Mr. Remmy Shawa (UNESCO ESARO), Ms. Juliette Faida Nsensele (IPPF Africa Regional Office), Ms. Sylvia Wong, Innovations Coordinator, UNFPA HQ, and Ms. Jane Ferguson (London School of Hygiene and Tropical

Medicine). We also thank the UNFPA Country Offices, representatives from Ministries of Health and Higher Education, universities, nursing colleges, regulatory institutions, civil society organizations, faith-based organizations and youth representatives who participated in the consultative process. Their role is critical to the successful use and roll-out of this guidance document.

The Relevance Network (TRN) conducted literature reviews, data analysis and expert consultations, wrote briefs and reports, planned and facilitated consultative meetings and workshops, and developed this guidance document. TRN team members included Mr. Craig Carty (Project Lead), Mr. Aidan Connolly (Technical Lead), Mr. Benjamin Fletcher (Methodologist), Ms. Kerry Rehse (Key Populations Expert), Ms. Elona Toska (Training and Facilitation Expert), Ms. Kimberly Crunkleton (Regional Advisor), and Ms. Charlene Flavell (Administrative Lead). Final technical editing was done by Dr. Bruce Dick (Independent consultant). Final editing was done by Ms. Mercedes Sayagues.

This report was developed with the technical and financial assistance of:



Implemented by:  
**giz** Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) GmbH



Schweizerische Eidgenossenschaft  
Confédération suisse  
Confederazione Svizzera  
Confederaziun svizra

**Swiss Agency for Development  
and Cooperation SDC**



**SUGGESTED CITATION:** United Nations Population Fund East and Southern Africa (2018), *A Regional Guidance: Strengthening Competency-Based Education in Adolescent Health in Pre- and In-Service Training for Health-Care Providers*. Johannesburg: UNFPA ESARO.

# Acronyms and Abbreviations

<b>ASRHR</b>	Adolescent Sexual and Reproductive Health and Rights
<b>AYFHS</b>	Adolescent and Youth Friendly Health Services
<b>AYP</b>	Adolescents and Young People
<b>CSO</b>	Civil Society Organization
<b>COMESA</b>	Common Market for Eastern and Southern Africa
<b>CPD</b>	Continuing Professional Development
<b>CBE</b>	Competence-Based Education
<b>CSE</b>	Comprehensive Sexuality Education
<b>EAC</b>	East African Community
<b>ESA</b>	East and Southern Africa
<b>EUTeach</b>	European Training in Effective Adolescent Care and Health
<b>FBO</b>	Faith Based Organization
<b>GIZ</b>	Deutsche Gesellschaft für Internationale Zusammenarbeit
<b>HCP</b>	Health-Care Provider
<b>HIV/AIDS</b>	Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome
<b>IGAD</b>	The Intergovernmental Authority on Development
<b>IPPF AR</b>	International Planned Parenthood Federation Africa Region
<b>MOE/MOHE</b>	Ministry of Education/Ministry of Higher Education
<b>MOH</b>	Ministry of Health
<b>NGO</b>	Non-Governmental Organization
<b>REC</b>	Regional Economic Community
<b>SADC</b>	Southern African Development Community
<b>SAHU</b>	Society of Adolescent Health in Uganda
<b>SRH</b>	Sexual and Reproductive Health
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>TRN</b>	The Relevance Network (Pty) Ltd.
<b>TWG</b>	Technical Working Group
<b>UNAIDS</b>	United Nations Programme on HIV/AIDS
<b>UNESCO</b>	United Nations Education, Scientific and Cultural Organization
<b>UNFPA</b>	United Nations Population Fund
<b>WHO</b>	World Health Organization



© UNFPA ESARO/Corrie Butler

# Definitions of Key Terms and Concepts

**Adolescent:** UNFPA/WHO/UNICEF's standard definition for an adolescent is an individual aged 10-19 years.

**Adolescent and Youth-friendly Health Services:** Health services that are both responsive and acceptable to the needs of adolescents and youth and which are provided in a non-judgmental, confidential and private environment, at times and locations that are convenient for adolescents and youth.<sup>1</sup>

**Adolescent Health:** Adolescent health is about enjoying positive development through complete physical, sexual, mental, and psychosocial health and well-being. A healthy adolescent is progressively acquiring the intellectual, social and emotional skills they will need to fulfil their potential as a healthy adult, equipped to contribute positively to society.

**Competency:** Sufficient knowledge and psychomotor, communication and decision-making skills and the attitudes to enable the performance of actions and specific tasks to a defined level of proficiency.

**Competency-Based Education:** Education and training that focuses on the development of sufficient knowledge, attitudes, skills and behaviours to enable the performance of specific actions and tasks to a defined level of proficiency and function effectively in a work setting.

**Curriculum:** The totality of learning activities that are designed to achieve specific educational outcomes. The term "curriculum" can refer to either a written document or the entire academic programme.

**Health-Care Provider:** For the purpose of this guidance document, this includes the range of health-care professionals and service providers, including medical doctors, nurses, midwives, clinical officers, counsellors, health educators, social workers and community health workers.

**Health Systems Strengthening:** The process of identifying and implementing the changes in policy and practice in a country's health system, so that the country can respond better to its health and health system challenges; any array of initiatives and strategies that improves one or more of the functions of the health system and that leads to better health through improvements in access, coverage, quality, or efficiency.

**Human Rights-based approach:** The recognition that all citizens have a right to health services, products and information and that individual States have an obligation to ensure that this right is respected, protected and fulfilled. Citizens have a corresponding responsibility to seek health services and to live healthy lifestyles.<sup>2</sup>

**In-Service Training:** Refers to training of selected health-care professionals to help them develop specific clinical skills. In-service training may be a part of continuous medical education or professional development for staff in the form of a study site visit, didactic lecture, short courses, supervision and mentoring of health-care providers.

**Levels of Training and Care:** When adapting and implementing this guidance to strengthen pre- and in-service training, it will be necessary to work at regional, national, state, provincial, district and facility levels. All these levels need to be taken into consideration.

**Pre-Service Training:** Learning that takes place in preparation for a future role, for example, as a doctor, midwife, nurse, social worker, counsellor or community worker. This education provides a broad array of knowledge, skills and attitudes needed to fulfil that future role and from which the student can later select what is needed in a specific situation. Pre-service education most often takes place in institutions of higher learning such as nursing, social work and medical schools, universities and colleges. It is important to understand the different challenges, opportunities and stakeholders likely to be involved with in-service training and pre-service training.

**Quality of Care:** WHO defines the quality dimensions of adolescent-friendly health services to describe services that are available, accessible, acceptable, appropriate, equitable and effective.

**Quality Standard:** A statement of a defined level of quality in the delivery of services required to meet the needs of intended beneficiaries. A standard defines the performance expectations, structures, or processes needed for an organization to provide safe, equitable, acceptable, accessible, effective and appropriate services.

**Young People:** UNFPA/WHO/UNICEF's standard definition for young people is individuals aged 10-24 years, which incorporates "adolescents" and "youth".

**Youth:** UNFPA/WHO/UNICEF's standard definition for youth is individuals aged 15-24 years, although the African Youth Charter of the African Union and a number of countries in the region define the upper limits of youth as 35 years.

# Executive Summary



© UNFPA Ethiopia/Mulugeta Wolde

Today more than one-third of the population in East and Southern Africa (ESA) is between the ages of 10 and 24. This current population of 182 million young people is expected to rise to 350 million by 2050.<sup>3</sup> The ESA region is thus in a unique position to leverage the potential of the demographic dividend, the economic growth that can arise when a population has a relatively large proportion of working-age people who have benefitted from investments in their health, empowerment, education, and employment.

This reality and related prospects have not gone unrecognized by regional leadership. Within the context of the [“Young People Today, Time to Act Now”](#) initiative, Ministers of Health and Education from 21 ESA countries that are members of the Southern African Development Community (SADC) and the East African Community (EAC) agreed to the ESA Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and youth

(December 2013). One of the ESA Commitment 2020 targets states: *“Pre- and in-service sexual and reproductive health (SRH) and comprehensive sexuality education (CSE) training for teachers, health and social workers are in place and being implemented”*. As a contribution to achieving this target, the United Nations Population Fund (UNFPA) East and Southern Africa Regional Office (ESARO) initiated a comprehensive process to develop a regional guidance document with the overarching aim of strengthening the adolescent health and development component of pre- and in-service competency-based education and training programmes for health-care providers (HCPs).

This guidance document builds on the [WHO global standards for quality health-care services for adolescents](#)<sup>4</sup> and the [WHO core competencies in adolescent health and development for primary care providers](#).<sup>5</sup> It is also aligned with the [Global Accelerated Action for the Health of Adolescents \(AA-HA!\): guidance to support country implementation](#).<sup>6</sup> It offers a strategic framework and processes to strengthen competency-based pre- and in-service training on adolescent health for health-care providers, as a contribution to achieving universal health coverage for all adolescents and youth in the region.

The document proposes three priority areas and two cross-cutting themes. The priority areas include:

- Supporting leadership, management and accountability;
- Developing consensus about the content and strategies for strengthening the adolescent health components of pre- and in-service training; and
- Increasing the quality and coverage of adolescent health in existing pre- and in-service training programmes.

The cross-cutting issues are monitoring and evaluation, and the meaningful involvement of adolescents and youth.

# Part 1. Introduction

## 1.1. Background and Context

More than one-third of the population in East and Southern Africa is aged 10 to 24 years, with the population of young people expected to rise from the current 182 million to 350 million by 2050. As a result of these changes, countries in the region will be able to benefit from the demographic dividend, the economic growth that can result when a population has a relatively large proportion of working-age people who have benefitted from interventions to improve their health, empowerment, education and employment. Young people can be a great force for social, economic and political change. However, this requires strong political leadership to realize the global commitments that have been made to increase the empowerment of girls and women, ensure universal quality education that is tailored to new economic opportunities, and increase secure employment and universal health care that promotes the well-being of all young people.<sup>7</sup>

The Lancet Commission on Adolescent Health and Well-being<sup>8</sup> reported that two-thirds of young people are growing up in countries where preventable and treatable health problems remain a daily threat to their “life chances”, e.g. HIV, early pregnancy, high-risk sexual activities, depression, injuries and violence. Adolescents and youth in sub-Saharan Africa are disproportionately affected. The Commission reiterated the importance of adolescent health to public health now and in the future, to the health of this generation and the next.

Adolescents' and young people's access to quality health information, education, and services, including sexual and reproductive health (SRH) services, is grounded in human rights. A number of global and regional commitments and policy statements highlight the intersections between health and education in meeting the development needs of young people within a rights-based framework. These international instruments include the United Nations (UN) *Convention on*

*the Rights of the Child* (1990); the 1994 *Programme of Action of the International Conference on Population Development* (ICPD, 1994); the 2001 *Millennium Development Goals* (MDG); the 2001 UN General Assembly Special Session (UNGASS) *Declaration of Commitment on HIV/AIDS*; General Comment No. 4 (2003), *Adolescent Health and Development in the Context of the Convention on the Rights of the Child*, General Comment No. 15 (2013) on the *Right of the Child to the Enjoyment of the Highest Attainable Standard of Health* (article 24), and the 2016 General Comment on the *Implementation of the Rights of the Child during Adolescence*.

Other recent global and regional commitments include the 2030 *Agenda for Sustainable Development* and the related *Global Strategy for Women's, Children's and Adolescents' Health* (2016-2030), the *Africa Health Strategy* (2016-2030), the SADC-sponsored *Resolution on Women, the Girl Child and HIV and AIDS* (2016) and its *Programme of Action* (2017), the revised *Maputo Plan of Action* (2016-2030) and the *AU Agenda 2063: The Africa We Want*. Each of these commitments and frameworks state that sustainable economic, social and environmental development will not be realized without investing in adolescent health and well-being through programmes implemented through health and other sectors.





### Targets:

- 3.1 Reduce maternal mortality
- 3.2 End preventable newborn and child deaths
- 3.3 End the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases (NTD)
- 3.4 Reduce premature mortality from non-communicable diseases (NCD) and promote mental health
- 3.5 Strengthen the prevention and treatment of substance abuse
- 3.6 Halve global deaths and injuries from road traffic accidents
- 3.7 Ensure universal access to sexual and reproductive health-care services

- 3.8 Achieve universal health coverage, including financial risk protection, access to quality essential health-care services
- 3.9 Reduce deaths and illnesses from hazardous chemicals and air, water and soil pollution and contamination

### Means of implementation targets:

- 3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries
- 3.b Provide access to affordable essential medicines and vaccines for all
- 3.c Increase health financing and the recruitment, development, training and retention of the health workforce in developing countries
- 3.d Strengthen capacity for early warning, risk reduction and management of national and global health risk

**Figure 1: Sustainable Development Goal 3:**

**Ensure healthy lives and promote well-being for all, at all ages.**

## 1.2. Rationale for the Regional Guidance

In the ESA region, the Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and youth<sup>9</sup>, which was adopted by 21 countries<sup>10</sup> in December 2013, aims to improve sexual and reproductive health and rights (SRHR) and HIV prevention among young people. The Commitment contributed to accelerated progress towards

achieving the 2015 Millennium Development Goals (MDG), and to developing the agenda for 2020. Eight targets were agreed that would help ensure effectiveness, impact and accountability, working within both a multisectoral and a whole-of-government approach. The eight ESA Ministerial Commitment targets are presented in Table 1.

**Table 1: ESA Ministerial Commitment 2015 and 2020 targets**

2015 TARGETS	2020 TARGETS
<ul style="list-style-type: none"> <li>• A good quality comprehensive sexuality education (CSE) curriculum framework is in place and being implemented.</li> <li>• Pre- and in-service sexual and reproductive health (SRH) and CSE training for teachers and health and social workers are being implemented.</li> <li>• Decrease the number of adolescents and young people who do not have access to youth-friendly SRH services by 50%. This includes equitable, accessible, acceptable, appropriate and effective services related to HIV.</li> </ul>	<ul style="list-style-type: none"> <li>• Consolidate recent and hard-won gains in the reduction of HIV prevalence in ESA and push towards eliminating all new HIV infections among adolescents and young people aged 10-24.</li> <li>• Increase to 95% the number of adolescents and young people, aged 10-24, who demonstrate comprehensive HIV prevention knowledge levels.</li> <li>• Reduce early and unintended pregnancies among young people by 75%.</li> <li>• Eliminate gender-based violence.</li> <li>• Eliminate child marriage.</li> </ul>

Regional and country reports on progress made towards achieving the ESA Commitment targets show that many countries in the region have some form of policy, strategy, standards and/or guidelines aimed at improving adolescent health. However, despite the presence of these frameworks,

the quality, coverage and uptake of health services have often been limited.<sup>11</sup> The low use of health services by adolescents and youth has been attributed to a range of factors, including the high cost of services; lack of information on availability of services; poor skills among service providers working with

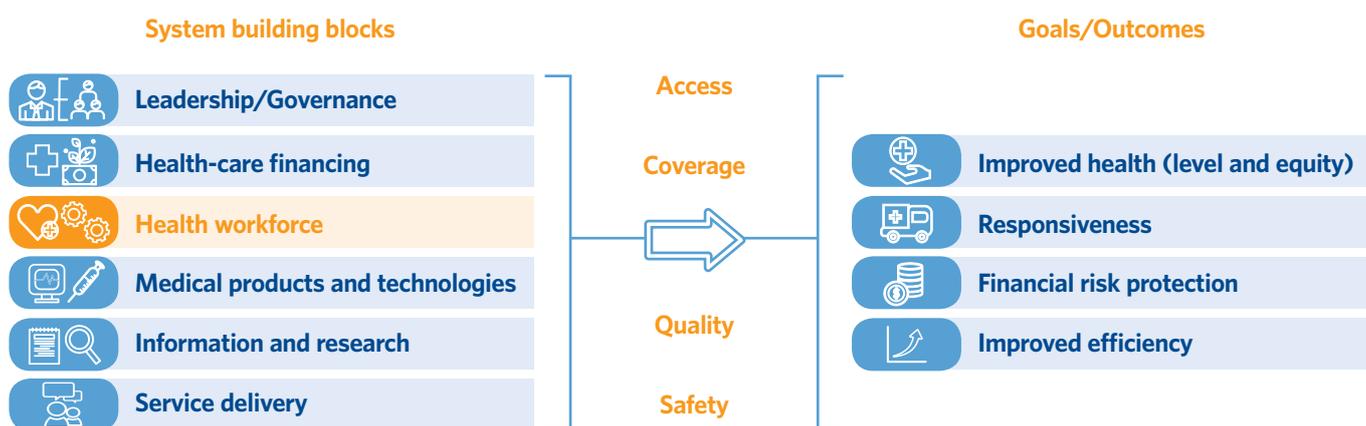
adolescents and youth; stigma, in particular associated with using SRH services; lack of privacy and confidentiality; and nuanced barriers related to the availability, accessibility, and acceptability of services.<sup>12,13,14</sup> These factors often lead young people to seek services outside the formal health systems, such as home remedies, traditional methods of contraception, clandestine abortions and misuse of over-the-counter medicines, with sometimes devastating consequences.<sup>15</sup>

Many things will need to be done to increase adolescents' access to health services. Developing standards and improving the quality and reach of training programmes designed for the range of HCPs working with young people is an important first step. While there appears to be a shared goal to make the health services responsive to the health needs of adolescents and young people (AYP), often the human resources required are neither available nor trained with the necessary competencies. This lack of capacity

makes it challenging for countries to implement and scale up effective service delivery models in a sustainable way, something that may be compounded by lack of coordination and limited and inconsistent financial resources from regional (e.g. Regional Economic Communities) and domestic sources.

It is increasingly recognized that improvements in the provision of health services to adolescents and youth need to be seen within the context of national priorities for achieving universal health care. In addition to being informed by primary data collection and analyses, this guidance document therefore reflects the recommendations of international and regional guidance for strengthening health systems as these relate both to the population in general and to young people in specific. It deals primarily with the health workforce building block of the WHO Health Systems Framework (see Figure 2) by focusing on ways to improve the competencies of HCPs with regards to adolescent health (see Table 2).

**Figure 2: WHO Health Systems Framework<sup>16</sup>**



**Table 2: WHO Global standards for quality health-care services for adolescents: Standard 4 on HCP's competencies**

Standard 4. HCPs' Competencies for Adolescent Health	
Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both health-care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude and respect	<b>Competency 1.1.</b> Understand normal adolescent development, its impact on health and its implications for health care and health promotion.
	<b>Competency 1.2.</b> Effectively interact with an adolescent client.
	<b>Competency 2.1.</b> Apply in clinical practice the laws and policies that affect adolescent health-care provision.
	<b>Competency 2.2.</b> Deliver services for adolescents in line with quality standards.
	<b>Competencies 3.1. – 3.13.</b> Clinical care of adolescents with specific conditions

Thus, in addition to contributing to SDG3, Universal Health Care and Strengthened Health Systems, this guidance document is framed by and supports the operationalization of the [WHO Global standards for quality health-care services for adolescents<sup>17</sup>](#), [Core competencies in adolescent health and development for primary care providers<sup>18</sup>](#) and the [Global Accelerated Action for the Health of Adolescents \(AA-HAI\)<sup>19</sup>](#) that aim to assist governments in deciding how they can best respond to the health needs of adolescents in their countries.

Although the Ministerial Commitment that inspired this guidance focused primarily on ASRH and HIV, the document addresses pre- and in-service training for adolescent health. The reason for this is that these entry points can promote a broader public health agenda, recognizing that the health problems of young people have common determinants and are often linked together in terms of cause and effect. It can therefore be expected that HCPs who provide services for young people are able to respond holistically to their health problems and health-related behaviours.

### 1.3. Process for Developing the Guidance

In 2015, UNFPA ESARO initiated a multi-year regional project to advance national adaptation, ownership and implementation of global and regional commitments and guidance. The project focuses on the ESA Commitment targets of improving access to youth-friendly SRH services, and strengthening pre- and in-service training for HCPs on adolescent and youth health and youth-friendly health services.

This regional guidance document, “Strengthening competency-based education on adolescent health in pre- and in-service training programmes for health-care providers”, is the culmination of a comprehensive process commissioned by UNFPA ESARO, in collaboration with a number of partners, including IPPF Africa Regional Office, WHO, UNESCO, UNAIDS, GIZ, COMESA, EAC, IGAD, SADC and civil society organizations.

The guidance is informed by the findings of a Regional Assessment of the Status of Institutionalization of Adolescent and Youth-Friendly Health Service Delivery (AYFHS) in pre- and in-service training institutions for health-care providers. The Assessment was based on a desk review and the analysis of primary data interviews with 54 pre-service and 31 in-service educators, and 434 pre-service and 19 in-service health-care trainees from across the region.

#### Key findings and recommendations from the study included:

- **Relevance of national policies and guidelines on AYFHS –**

The majority of respondents reported that their country had specific national policies, guidelines or standards of relevance to adolescent health, adolescent SRHR and AYFHS. However, some participants, especially pre-service students, indicated that the content of the training they received did not respond to these national policies, standards and strategic frameworks. This highlights the need to both develop pre-service training curricula appropriately, and to have regular orientations on national policies relevant to adolescent health in in-service training.

- **Coverage of capacity building of trainers and trainees –**

The majority of pre-service educators reported that they had received no training on adolescent and youth health and development and/or quality AYFHS, and that refresher courses and mentorship for trainers were lacking. The assessment concluded that capacity building of pre- and in-service health-care educators and trainers is generally not sufficient to enable them to deliver and train on adolescent health and the provision of quality AYFHS.

- **Course structure and information on adolescent and youth health and/or AYFHS –**

Only half of respondents (both service providers and educators) thought that current training adequately addressed adolescent and youth health and development. The numbers who reported that sufficient attention was given to quality adolescent and youth-friendly health services were even lower. The duration of training courses (integrated or stand-alone training) on AYFHS delivery was deemed too short to allow for reflection, comprehension and skills development by many pre- and in-service trainers and trainees.

- **Training methodologies –** Training methodologies and delivery approaches in the curricula, manuals and training support materials were reported to be generally neither participatory nor conducive to adult learning. Use of case studies, clinical practice and values clarification exercises was much lower for pre-service training programmes than for in-service trainings. Capacity building of health-care providers in pre- and in-service trainings was often not competency-based, with limited focus on specific adolescent health issues and related skills. More focus is needed on the consultation setting and on interpersonal and communication skills that need to be applied during taking a history, psychosocial assessment, physical examination, motivational interviewing and assisting adolescents and youth to make informed decisions.

- **Training programme content –** There were few differences between countries in terms of the content of the pre- and

in-service training programmes. However, the clinical case management for the in-service training materials varied in quality, often lacked an adolescent focus and many adolescent-specific clinical situations (e.g. mental health) were absent. The study concluded that the curricula and content of the training materials need to be elaborated in both pre- and in-service curricula and support materials, and that they should be aligned with the latest international guidance on adolescent health and AYFHS, and with relevant national policies, standards and strategic frameworks. In addition, there should be more context-specific content that responds to the specific epidemiological profile of young people in the country and takes into account the specific needs of subcategories of adolescents and youth, including the needs of vulnerable populations. In order to provide quality AYFHS, health-care providers need to be well trained with the right skill set, attitudes and knowledge.

- **Coordination with other sectors** – Only around half of educators and trainees thought that health-care professionals collaborated well with schools and other community-based programmes and facilities that provide health services for adolescents.

- **Monitoring and evaluation** – Most Ministries of Health reported that they lacked a database of health providers trained in the area of adolescent health or AYFHS, as such trainings are often conducted by different institutions (MOH, NGOs, UN, etc.). This made it difficult for MOH to monitor where trained providers are working, assess the impact of the training and follow up for supervision and quality assurance after their trainings.

The above findings were discussed at an ESA regional consultative meeting convened in November 2016. The outcomes of this meeting were combined with the primary data analyses and additional stakeholder insights to form a “Background Report”<sup>21</sup> that informed the development of this guidance. An initial draft of the guidance was validated through a participatory process that included face-to-face meetings and reviews by various stakeholders from the ESA region, including government officials from ministries of health and education, professional associations and training institutions, academia, representatives from SADC, EAC and COMESA, UN partners, donors and young people.



©UNFPA ESARO/Corrie Butler

# Part 2. Strategic Framework

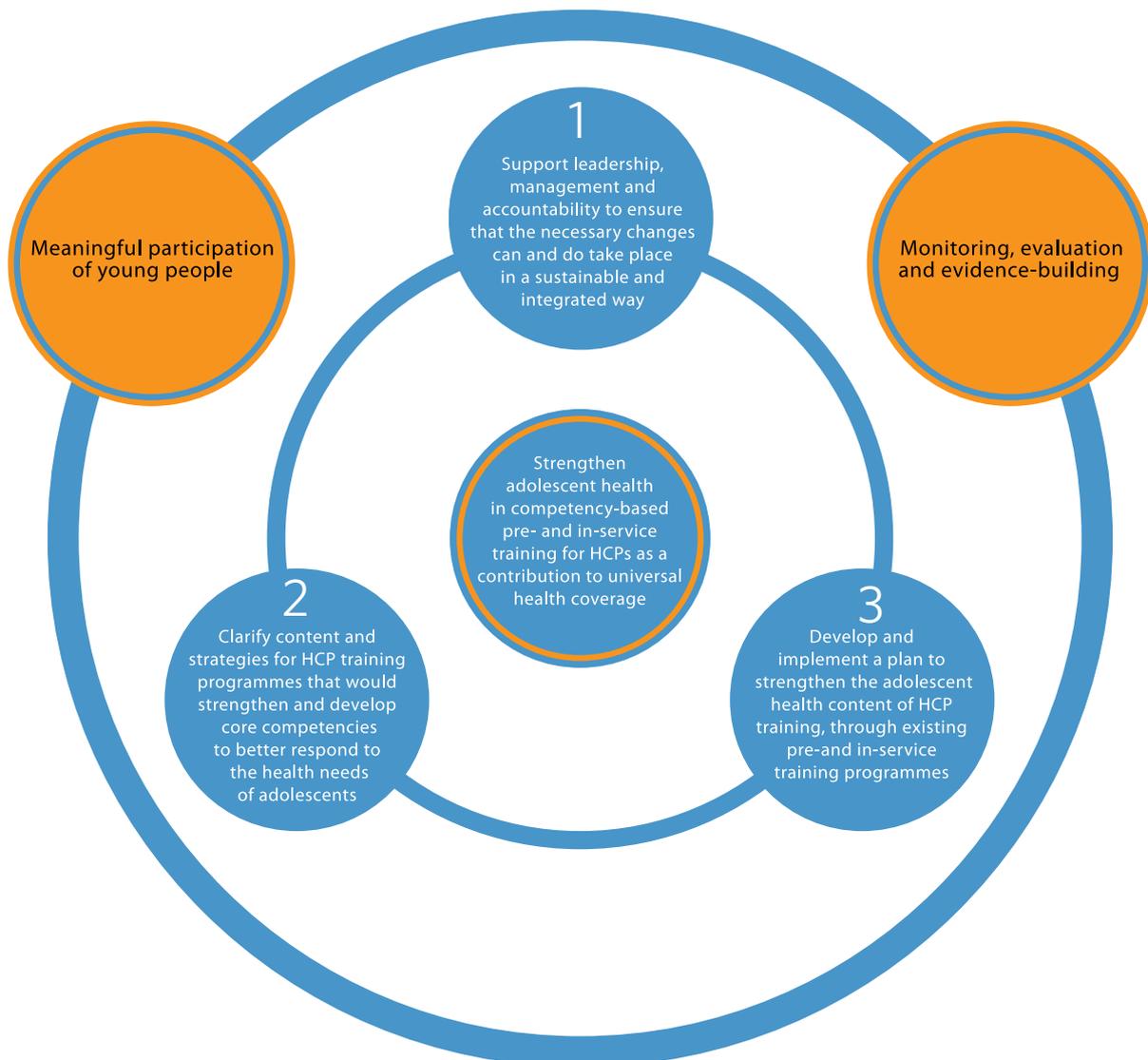
The strategic framework for the Strengthening Competency-Based Education (CBE) on Adolescent Health for HCPs is presented in Figure 3. The framework outlines the main actions to consider in strengthening the adolescent health components of pre- and in-service training for HCPs:

- Generating support for action through leadership, management and accountability for the necessary changes;
- Being clear about the content of and strategies for HCP training that would strengthen and develop their competencies to better respond to the needs of adolescents;

- Developing an action plan to implement essential adolescent health components through existing pre- and in-service training programmes.

These actions should be informed by the meaningful involvement of adolescents and young people<sup>22</sup> in the design, implementation, and monitoring of the training, and assessed through an integrated monitoring and evaluation system. They may be undertaken sequentially or in parallel depending on the conclusions of the assessment of needs and gaps for pre-and in-service training on adolescent health (See Fig. 3).

**Figure 3: Priority activities to strengthen the adolescent health component of pre- and in-service training for HCPs, as a contribution to achieving universal health care for adolescents.**



# Part 3. Guiding Principles

The following guiding principles should underpin efforts to strengthen the adolescent component of pre- and in-service training programmes for HCPs and the use of this guidance document. They reflect the values and guiding principles for programmes for adolescent health, HIV and SRH outlined in other publications.<sup>23</sup>

- **Based on evidence and responding to specific contexts:**

This regional guidance must be used as appropriate to country-specific settings. To ensure relevance, sustainability and ownership, evidence will be needed about characteristics of the country, the overall socio-economic context, existing health and education systems, available resources, and the epidemiology, burden of disease and priority health problems of adolescents.

- **Identifying strategic entry points:** Adolescent health includes different causes of death, lost disability-adjusted life years (DALYs) and health-related behaviours that vary depending on age, gender and other factors such as economic status and ethnicity. In ESA, ASRH problems and HIV remain important entry points for action for adolescent health. At the same time, it is important for countries to monitor changing health priorities and use them strategically as entry points for improved HCP training.

- **Human rights centred, age and gender sensitive and respectful of confidentiality:** Pre- and in-service training needs to highlight that States have an obligation to provide health services to all young people in ways that take gender differences into consideration, are age-appropriate, and give adequate attention to adolescents' evolving capacities, are equitable and meet the needs of vulnerable adolescents and youth, and ensure privacy and respect for the confidentiality of the young people who use the services.

- **Contributing to universal health coverage:** The overall aim of strengthening the adolescent health component of competency-based pre- and in-service training is to assist countries achieve universal health coverage for adolescents – issues of sustainability, integration and the institutionalization

of training programmes need to be considered in order to increase the coverage and quality of priority services for this segment of the population.

- **Involving young people and developing partnerships:**

Young people need to be strategically involved with developments to existing pre- and in-service training programmes, in partnership with a range of stakeholders that can help strengthen HCP training, e.g. different government departments, civil society organizations, national and international NGOs, UN agencies and the private sector.

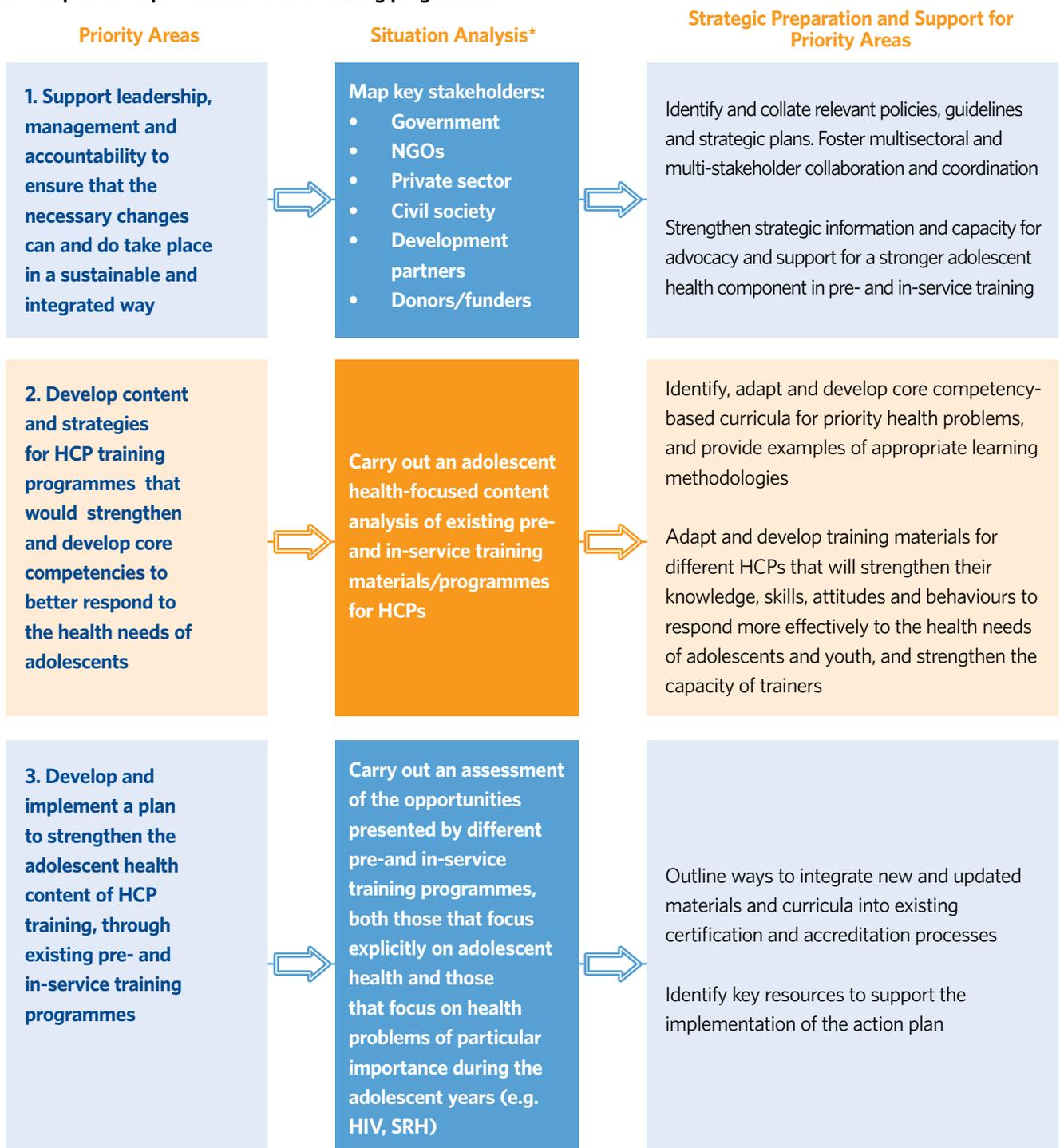


© UNFPA Ethiopia / Mulugeta Wolde

# Part 4. Priority Areas

This section describes the three priority areas to be considered. Each priority area includes a situation assessment, strategic preparation, and supportive activities (Figure 4). The Annex 1 contains checklists to assess progress at different levels of training and care and examples of promising practices.

**Figure 4: Key activities that countries could consider when developing plans to strengthen the competency-based adolescent health component of pre- and in-service training programmes**



\* All the activities included in this column relate to different components of a situation analysis and may be carried out at the same time or sequentially depending on the main information gaps.

## 4.1. Support leadership, management and accountability to ensure that the necessary changes take place in a sustainable and integrated way

### 4.1.1. Map key stakeholders

*Senior level political and technical ownership is critical to strengthening the adolescent health content of training programmes for HCPs, and the ESA Commitment review from 2016<sup>24</sup> stressed the key role of government.*

**A number of government ministries and professional associations can provide leadership, management and systems of accountability:**

- **For pre-service training:** leadership from the Ministry of Health, Gender and Social Development and/or Ministry of Education and regulating authorities (e.g. the national board of licensing and certification, qualifications and curriculum development agencies, professional associations); and
- **For in-service training:** leadership from the MoH, relevant professional and/or training regulating bodies.

NGOs are likely to be involved as well. From the outset, it is important to know who are the key actors and stakeholders in the fields of adolescent health, workforce development and health systems strengthening. Mapping stakeholders in these areas with their specific roles and responsibilities will improve coordination, avoid overlap, and increase the quality and coverage of training programmes. [See the Matrix and Questionnaire to map stakeholders in Annex 1.](#)

While assessments show that there is some level of dedicated adolescent health focus within MoH in most countries in the ESA region, the placement of departments and units and the relative seniority of assigned personnel vary. Roles, responsibilities and systems for coordination for pre- and in-service training on adolescent health need to be understood, as well as the advantages and disadvantages to the different approaches.<sup>i</sup>

**It is important from the beginning to:**

- Be clear about the organization and roles of the focal person(s) or department that is responsible for driving

the adolescent health agenda, including adolescent health training for HCPs; and

- Identify key areas of support needed to strengthen the capacity of the focal person, department and/or institution, so that they can more effectively lead, manage and develop systems of accountability for pre- and in-service training. ([See Questions to help clarify the structure of adolescent health responsibilities within the Ministry of Health and other sectors, Annex 1\).](#)

There are a number of health manager development programmes and courses that are applicable to ESA but there are currently no adolescent health-specific management programmes in the region. However, some countries have taken strides to incorporate management and leadership skills into their pre-service training programmes. In Zambia, for example, the core competency areas of the national registered nurse curriculum include data management and use, mentorship and coaching, research, personal effectiveness, quality assurance, advocacy, networking with stakeholders, and assertiveness training, on top of their core competencies as nurses.<sup>25</sup> In 2017, South Africa piloted an Adolescent & Youth Health Policy Short Course for mid-level managers responsible for rolling out its new Policy.<sup>26</sup> The Short Course was scaled up to Zambia and Zimbabwe in 2018.

### 4.1.2. Identify and collate relevant policies, guidelines and strategic plans, and foster multisectoral and multi-stakeholder collaboration and coordination

A recent analysis of ASRHR policies and strategic plans in the ESA region<sup>27</sup> found that most countries have a health policy that refers to adolescents and young people and their access to health services. However, there are variations across the region:

- **Timeliness:** How recently the policy and strategies has been enacted and/or updated<sup>ii</sup>;
- **Alignment:** How they reference and build on global and regional commitments and WHO standards;
- **Collaboration:** The degree to which they directly or indirectly link responsible departments and/or sectors such as health, education, gender and youth; and
- **Implementation:** The extent to which the policies are disseminated and implemented by relevant institutions, including pre-service training institutions and those responsible for in-service training.

<sup>i</sup> See relevant sections in the on-line Health for the World's Adolescents and the Global AA-HA! Guidance document.

The content of existing policies, guidelines and regulatory frameworks must be reflected in both pre- and in-service training programmes to indicate national priorities and approaches to improving the health and development of young people. Policies and guidelines are the basis for collaboration between a range of partners with whom the HCPs trained will work to achieve national goals and targets for adolescent and youth health.

The ESA Commitment accountability framework stresses the importance of strengthening collaborations between different sectors and stakeholders, including young people. This can often be done through strengthening existing structures and working groups focusing on health service provision in general and adolescent health in specific.

Regional experience indicates that the links between MoH, MOE, MOHE, professional associations and training institutions at both the pre- and in-service levels is often weak. Having key training institution contact points and regulatory authority focal points meet regularly through existing fora may help strengthen such linkages. Where such multisectoral fora exist, they should be utilized and strengthened; where they don't exist, they may need to be created.

Examples of strengthened ESA country-level multi-stakeholder working groups include the Adolescent Health Technical Working Group in Zambia and the National School Health Task Force in Namibia. Uganda's National Society for Adolescent Health is an example of strengthened coordination between stakeholders, including the involvement of young people ([see Annex 2, Strengthening coordination and collaboration: the Society for Adolescent Health, Uganda](#)).

#### **4.1.3. Strengthen strategic information and capacity for advocacy and support for a stronger adolescent health component in pre- and in-service training**

**In addition to improving coordination mechanisms, advocacy for greater attention to adolescent health in pre- and in-service training could be strengthened through:**

- **Sharing information** among stakeholders and building the evidence base for the importance of adolescent

health in the national context and the need for capacity development to respond to young people's health needs;

- **Aligning with regional efforts, policies and guidelines**, e.g. the Africa Health Strategy, the Maputo Plan of Action and SADC Regional Qualifications Framework;
- **Combining the efforts of a range of stakeholders involved with pre- and in-service training**, especially to identify opportunities to leverage in-service training materials and approaches to strengthen competency-based pre-service training;
- **Ensuring adequate budget allocations and galvanizing donor support** to strengthen monitoring and follow-up, and to fill gaps.

Having a good overall situation analysis of young people's health and burden of disease is central to effective advocacy for an improved response to the health needs of young people and the human resources needed to implement and scale appropriate and effective services in a sustainable way. It is important to make a compelling case for increased resources to be directed to adolescent health for the current burden of disease during adolescence, for their health when they become adults, and for the health of their children.

**A detailed understanding of the priority health problems that affect young people is not only important for advocacy but also for determining the content of CBE on adolescent health in pre- and in-service training. A good situation analysis of the burden of disease should be complemented by data from available assessments and projections of HCP workforce analyses, including:**

- Estimations of current availability and projected future demand for services;
- Health system performance and gaps in responding to the current and projected needs (as perceived by managers, service providers and clients);
- Capacity and resources (human, physical, financial, informational) of the health sector to respond to current and future needs and challenges;
- Stakeholder perspectives on workforce priorities and developments (including, where appropriate, those of external partners).

<sup>ii</sup> Though there is no uniform practices and guidelines for the regularity of updating policies, the regional review shows that most adolescent health/ASRHR policies are renewed every five years.

## 4.2. Develop content and strategies for HCP training programmes that will strengthen and develop core competencies to better respond to the health needs of adolescents

### 4.2.1. Carry out an adolescent health-focused content analysis of existing pre- and in-service training materials/programmes for HCPs

Section 4 of the WHO tool to assess the adolescent health and development component in pre-service education for HCPs will be useful in the analysis of existing training programmes.<sup>29</sup> This may be carried out consecutively or concurrently with the stakeholder mapping exercise, the assessment of the burden of disease and the workforce analysis.

**A situation analysis of adolescent health in pre- and in-service training of HCPs may include a review of the degree of adolescent health integration in pre-service and in-service training:**

- How many pre- and in-service institutions/providers operate in the country, region and province?
- Are topics in adolescent health (biological and neurocognitive development, sexual and reproductive health, standards for AYFHS, etc.) already included in training offered in these institutions? If so, to what extent?
- Which HCP cadres are being taught in these facilities?
- What is the focus/content of the curricula and the extent of their alignment with national and international guidelines and standards?
- Are the trainings conducted as stand-alone or integrated topics?

**It may also include an assessment of the existing adolescent health competencies of trainers and HCPs focusing on:**

- Pre-service training institutions: Students and teaching staff;
- Continuous professional development of trainers as part of in-service training;
- On-the-job trainers; and
- Supervision and mentoring in health-care facilities.

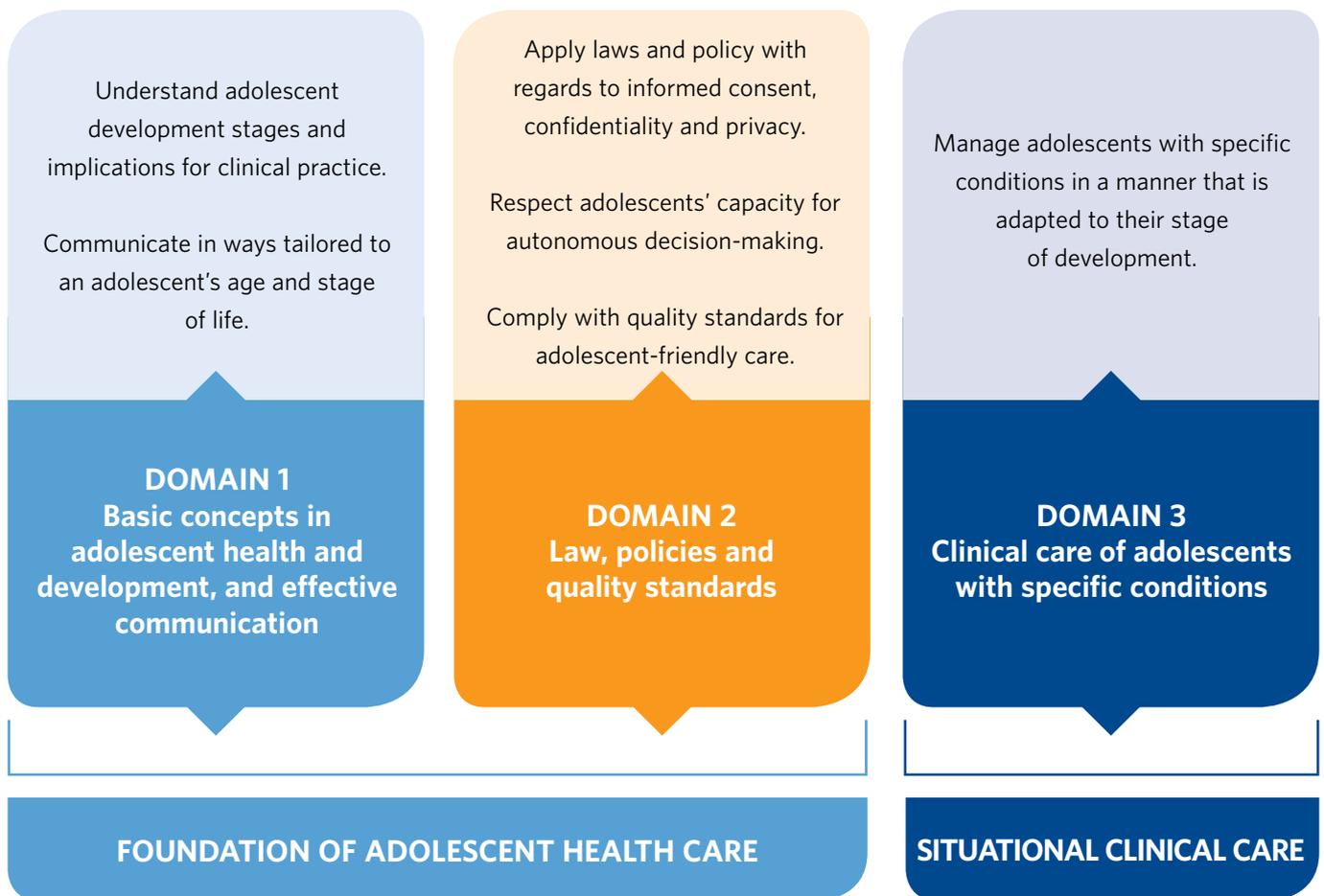
In terms of content, areas where capacity strengthening may be needed include: Better understanding of important adolescent health issues in the country (SRHR and beyond); availability, quality and scope of adolescent and youth-friendly/responsive health service delivery; programme planning; implementation and scaling up of specific interventions; monitoring and evaluation; strengthening health information management systems (HMIS); analysing and using age and gender disaggregated data for decision-making; advocacy, and resource allocation.<sup>30</sup>

Some content may have specific challenges. For example, integrating ASRH within existing pre- and in-service training may be more difficult than other topics, such as SRHR, because of the sensitivity and sometimes opposition to addressing adolescent sexuality; the need to overcome latent or explicit biases among HCPs or to facilitate values clarification for MoH staff who may not necessarily be involved directly with service delivery but are responsible for capacity development plans and/or resources allocation. Finally, it needs to be recognized that content is likely to be different in pre- and in-service training, even where the training targets the same cadre of HCP (see Table 3). [See also Annex 1, Questions to support the review of adolescent health training for HCPs and Questions to support the review of training programmes and materials for competency-based education on adolescent health in pre- and in-service training, and CPD.](#)

### 4.2.2. Identify, adapt and develop core competency-based curricula content and materials for priority health problems, provide examples of appropriate learning methodologies and identify potential trainers

There is an extensive body of international and regional guidance on adolescent health core competencies for HCPs. These include guidelines developed by WHO and its partner organizations<sup>31</sup>, such as materials in the [Health for the World's Adolescents](#)<sup>32</sup>, [Core competencies in adolescent health and development for primary care providers](#)<sup>33</sup>, [the Global Accelerated Action for the Health of Adolescents \(AA-HA!\)](#)<sup>34</sup>, and the [Orientation Programme on Adolescent Health for Health-care Providers](#) (specifically Section One that contains the core modules).<sup>35</sup>

**Figure 5: WHO Core Competencies in adolescent health and development for primary care providers**



These documents, based on evidence and internationally agreed good practice, outline the core competencies that health-care providers should have to comprehensively address adolescent health and development needs and provide adolescent and youth-friendly services<sup>36</sup> (see Fig. 5).

There are several ways in which the guidance can inform national efforts. First, if there are no adolescent health core competencies incorporated into existing HCP training at national level, the guidance can provide content that can be adapted to the local context. Second, if national adolescent health core competency training programmes exist, they may benefit from being reviewed in the light of international and regional guidance. The tool included as an annex to the WHO core competencies publication serves as a baseline for curricula assessment as well as a roadmap for building an ideal curriculum.

**The adapted competencies can then:**

- Be incorporated as part of a minimum package for adolescent health in national adolescent health policies or national guidelines for training HCPs developed by the MoH, MOE or MOHE;
- Inform the curriculum content for the adolescent health

component in pre- and in-service training; and

- Be integrated into national certification and accreditation systems.

Another useful tool is the [European Training in Effective Adolescent Care and Health \(EuTEACH\)](#), which offers 25 training modules and materials on Adolescent Health. EuTEACH offers a variety of teaching tools, videos, and power points to build trainer capacity and also has a network of health-care professionals who give long-distance advice to fellow HCPs who wish to develop AYFHS training programmes in their country. [A sample of the modules is found in Annex 1.](#)<sup>37</sup>

Effective adult learning methodologies can be applied to both pre- and in-service training programmes, as follows:

- Innovative and participatory methodologies are more effective;
- “Classroom-based” learning is complemented by mentorship and on-the-job supervision to ensure knowledge translates into practice;
- Pre- and in-service training programmes may require a different set of learning/teaching methodologies.

For example, given that most participants in pre-service training are young, the structure, content, and methodologies of the programmes can capitalize on this; and

- Although young people may not have the skills and experience, their involvement in pre- and in-service training programmes can be meaningful as expert patients or through case studies, role-plays, and open discussions.

[The Developing CBE on adolescent health for HCPs—the learning pyramid, found in Annex 1](#), shows the relative ineffectiveness of more traditional and passive methodologies when compared with innovative and participatory methodologies. Using this tool to guide the process of applying learning and teaching techniques could yield substantive outcomes for trainers and trainees.

#### **4.2.3. Adapt and develop training materials for different HCPs that would strengthen their knowledge, skills, attitudes and behaviours to respond more effectively to the health needs of adolescents and youth**

Competency-based curricula and training materials should be designed to meet the expected competencies of each cadre of HCP as determined by national professional and registration bodies and institutional/facility requirements. They should also be based on the burden of disease, which for ESA countries will likely include both ongoing health priorities such as those linked to ASRH, e.g. adolescent pregnancy and HIV, and other challenges such as injuries and violence, mental health and health-related behaviours such as substance use and diet.

A number of factors need to be considered when planning for the specific training needs of different HCPs.

##### **These include:**

- The specific roles and responsibilities of different HCPs and how these affect the knowledge, skills, attitudes and behaviours that need to be developed. The different tasks of HCPs have implications for training to ensure that those HCPs who have management, training or supervision responsibilities for other HCPs are given priority;
- The spectrum of health problems seen by different HCPs and the balance between curative and promotive/preventive activities should influence the focus and content of the training. Even within the same area, the

types of problems and programmes that community health workers primarily deal with may differ from doctors and nurses working in hospitals. Similarly, staff working in more specialized settings may require more focused training;

- The availability of existing pre- and in-service training programmes where a focus on adolescent health could be incorporated, rather than setting-up additional training programmes specifically focused on adolescent health, will likely vary among HCPs. Similarly, the time that is available for training different HCPs will influence what can be included. On the other hand, many of the skills and attitudes at the centre of CBE for adolescent health are of importance to the provision of health care for other groups of the population;
- It may be easier to combine different groups of HCPs in one training programme with in-service training. This has been done effectively with WHO's Orientation Programme on Adolescent Health for HCPs, and with EuTEACH trainings; and
- The availability of resources, including money, targeted training materials and trainers will influence what is possible. Developing training materials for a wide range of HCPs is likely to make best use of limited resources. When adapting materials, consider a range of issues, e.g. the languages spoken by HCPs working in different settings will determine the logistical planning for translation and adaptation.

For all of the above, training can only be as good as the expertise and capacity of the trainers. The issue of limited training opportunities for trainers featured prominently in the initial assessment carried out by UNFPA ESARO. Countries will need to invest in developing the capacity of trainers. WHO and EuTEACH provide some trainer-specific materials, though more is required to adapt these for the ESA region. One possibility is to include pre-service instructors in in-service adolescent health training sessions and practicums conducted by either the government or NGOs, especially trainings at a master level. In-service trainers could also schedule training specifically for people involved with pre-service training, using a train-the-trainer approach.

The inclusion of a focus on adolescent health in CPD will have implications for the training of staff responsible for the supervision and mentorship of a range of HCPs.

## 4.3. Develop and implement a plan to strengthen the adolescent health content of HCP training through existing pre- and in-service training programmes

### 4.3.1. Assess opportunities presented by different pre-and in-service training programmes, both those that focus explicitly on adolescent health and those that focus on health problems of importance during the adolescent years

Prior to developing a plan, as outlined above, a number of steps must be taken, including: Support mobilized to strengthen CBE on adolescent health in the pre- and in-service training of HCPs; clarity about the core content of the training required to develop the necessary knowledge, skills, attitudes and behaviours of different groups of HCPs; training methods agreed, and training materials identified that can be adapted to different country contexts. Only then is it possible to identify opportunities to pilot and scale up relevant training on adolescent health for a range of HCPs in different settings.

The bulk of the trainings on adolescent health that have been carried out in countries in the ESA region to date have been in-service trainings. These have often been stand-alone trainings supported by UN organizations and NGOs, within the context of achieving national standards for adolescent and youth-friendly health services.

The challenge now will be to strengthen the adolescent health component of pre-service training for different groups of HCPs; and to systematize in-service training by incorporating it into national efforts to improve the coverage, quality and sustainability of health services, as a contribution to achieving universal health care.

Pre-service and in-service education and training programmes provide different opportunities and challenges for developing competencies in adolescent health. Some are summarized in Table 3:

**Table 3: Characteristics of in-service and pre-service training programmes to consider when strengthening the adolescent health component of HCP training**

	PRE-SERVICE	IN-SERVICE
<b>Links to national health workforce projections</b>	Yes	Less likely
<b>Professional standards requirements (statutory for practice)</b>	Likely to be a requirement for professional practice	While some in-service training may be a requirement (CPD), it is likely to be more flexible
<b>Potential for change</b>	Significant planning required	More flexibility for change
<b>Competition for change</b>	Significant competition for subjects to be incorporated into pre-service training	More scope for additional in-service training if resources are available
<b>Coverage</b>	All HCPs	May be limited (especially if training organized by NGOs)
<b>Content</b>	Adolescent health may be developed as a stand-alone module or integrated throughout the curriculum	Can be tailored to the needs of a range of HCPs working on different health issues, with different populations groups and in different settings
<b>Levels of standardization</b>	High levels of standardization	More flexibility to introduce new training modules
<b>Responsibilities for change</b>	MoH, MOHE	MoH - may be possible at regional/provincial level rather than national level
<b>Responsibility for the training</b>	Government/university	A range of partners including government, professional organizations, NGOs

In general, there are significant pressures on pre-service training programmes to include additional content. At the same time, the approaches to education and training may not be strongly based on adult learning good practices. The challenge is therefore to explore ways of both integrating a focus on adolescent health throughout the curriculum and in stand-alone sessions, and to promote more interactive approaches to CBE in general.

In terms of in-service training, training programmes for different groups will need to be reviewed to identify opportunities to strengthen the adolescent health content and the quality of the training. This includes specific training for people working primarily with adolescents, such as HCPs working in primary care or on specific health issues of importance to adolescents, such as HIV, family planning and contraception, and people involved with programmes directed to vulnerable groups or settings, e.g. humanitarian situations.

In addition, it will be important to explore the opportunities for a stronger focus on adolescent health in CPD initiatives and requirements.

#### 4.3.2. Outline ways to integrate new and updated materials and curricula into existing certification and accreditation processes

Although the words “accreditation” and “certification” are often used interchangeably, they refer to different aspects of



efforts to maintain the quality of HCPs' performance: Accreditation is a formal recognition of an institution's ability to develop the competence of trainees to perform specific tasks; certification is the process of verifying that an individual has achieved a certain level of compliance within a particular area.

Accreditation and certification are not necessary for adolescent health components to be included into pre- and in-service training programmes, but may be considered important in certain contexts. In some countries, for example, institutions that coordinate qualification frameworks are mandated to develop curricula for national qualifications/degrees.

#### It is therefore important to understand the processes for certifying and accrediting pre- and in-service training:

- How can introducing or strengthening the adolescent health component of pre- and in-service training fit within the existing certification and accreditation processes?
- What are the current criteria that need to be fulfilled to obtain certification and accreditation?
- Who are the key actors in the process of certification and accreditation?

Countries may decide to institute an accreditation process as a means of officially endorsing curricula that meets all quality adolescent health core competencies. Certification and accreditation standards will vary according to the core technical and soft skill competencies for adolescent health that are required of different HCPs. Reviewing the current accreditation and certification processes by cadre of HCPs in the country will inform how adolescent health and development materials should be developed and integrated into existing pre- or in-service training materials.

#### 4.3.3. Develop an action plan and identify key resources to support its implementation

**The main issues to consider when developing an action plan to strengthen competency-based education on adolescent health in pre- and in-service training for HCPs have been outlined in the previous sections and are summarized below:**

- **A situation analysis** that includes both an assessment of the major health needs of young people and the needs of HCPs for specific training related to adolescent health and development;

- **A landscape analysis** of current CBE that focus on adolescent health, and the identification of global, regional and national guidance on CBE for adolescent health that can be adapted for national level programmes; and
- **Priority setting** in terms of key content, opportunities and channels for strengthening and developing CBE on adolescent health, and the main HCPs who need to be trained.
- **Physical resources:** What training programme support materials are available for different courses and different HCPs? Do they require adaptation, and if so by whom and with what support? Is translation needed for these training materials? How, where and when will the courses be delivered?
- **Financial resources:** Which budget lines will support the implementation of the action plan? What are the gaps? What additional funding sources, including national and external donors, may be required?

**In addition, it will be necessary to establish what human, physical, and financial resources are available and needed to put the plan into action, including:**

- **Human resources:** Which key people and institutions are pivotal to the success of the plan? How can their availability be maximized to ensure that the plan will be implemented? Who can provide support and guidance on the action plan implementation, from national, regional or global levels?

Listing the detailed steps for developing an action plan is beyond the scope of this guidance document. [However, some key questions are included in Annex 1. Questions to support the development of an action plan for strengthening adolescent health in training programmes.](#)



# Part 5. Cross-Cutting Themes

Throughout the consultations to develop this guidance document, two themes emerged consistently: Monitoring, evaluation and learning; and the meaningful engagement of adolescents in strengthening CBE for adolescent health. As these themes are relevant to the priority actions, they are discussed in detail in this section.

## 5.1. Monitoring, Evaluation and Learning

### 5.1.1. Develop a framework for monitoring and evaluation

The development of the competencies of HCPs in adolescent health is only one of a number of improvements that needs to be made to ensure that adolescent and youth-friendly health are available and used by young people. Furthermore, AYFHS are only one of many interventions required to improve the health and development of young people, including their sexual and reproductive health.

Monitoring and evaluation frameworks will need to focus primarily on inputs, processes, outputs and outcomes, rather than looking at impact, tracking changes in the process of teaching, how the adolescent health component of HCP training is taught, and the outcomes in terms of competencies developed.

**Table 4: Examples of adolescent CBE inputs, processes, and outputs relevant for monitoring and evaluation**

PRIORITY AREAS	MONITORING PROGRESS		
	INPUTS/PROCESSES	OUTPUTS	OUTCOMES
<b>1. Support leadership, management and accountability to ensure that the necessary changes take place in a sustainable and integrated way</b>	<p>Key stakeholders have been identified</p> <p>Key policies, guidelines and strategic plans have been collated</p>	<p>Information required for advocacy has been completed</p> <p>Advocacy for stakeholders carried out</p>	<p>High-level support for adolescent health in pre- and in-service training is in evidence</p> <p>Common understanding about the need to invest in an adolescent-competent workforce across sectors and agencies</p> <p>Systems for coordination strengthened</p>
<b>2. Develop content and strategies for HCP training programmes that would strengthen and develop core competencies to better respond to the health needs of adolescents</b>	<p>Existing training courses/ programmes have been identified</p> <p>Global and national training materials have been identified</p>	<p>Assessment of existing courses has been carried out</p> <p>National core competencies defined based on WHO criteria</p> <p>Materials have been developed or adapted for different HCPs</p>	<p>Opportunities identified to integrate adolescent health into existing pre- and in-service training and CPD</p> <p>Competency in adolescent health included in the job descriptions of relevant HCPs</p> <p>Educators have been trained (qualified trainers available)</p>

**Table 4: Examples of adolescent CBE inputs, processes, and outputs relevant for monitoring and evaluation (continued)**

PRIORITY AREAS	MONITORING PROGRESS		
	INPUTS/PROCESSES	OUTPUTS	OUTCOMES
3. Develop and implement a plan to strengthen the adolescent health content of HCP training, through existing pre- and in-service training programmes	CBE being implemented through a range of institutions in pre- and in-service training	HCPs have been trained	HCPs have developed core competencies*
		Systems for supportive supervision and mentoring in place	
		Budget line for training in adolescent health; resources available to support training and supervision	
		Ongoing systems in place for reviewing HCP needs for training and that existing training programmes meet their needs	

\*Core competencies in adolescent health and development could be assessed at five levels.<sup>18</sup>

1. Student self-assessment, to assess their own professional growth and levels of knowledge, skills and attitudes in the core competencies;
2. Student assessment, to examine students' core competencies in adolescent health by means of formative and summative assessment methods;
3. Educators' self-assessments, to gauge their own performance in teaching and professional growth;
4. Training institution capacity, to assess a faculty's capacity to teach adolescent health and whether the institution has a plan for staff development;
5. National evaluation of the adolescent health component in pre-service education, to assess educational quality nationwide and the performance of educators and students in meeting the standards, and to inform planning for appropriate interventions at the national level.

**5.1.2. Develop systems to certify trainers and track HCPs who are trained in adolescent health CBE**

Consideration should be given to establishing model training programmes, packages of materials, assessment

methods for trainers and a database that links the output of training institutions, relevant government departments, development partners and civil society organizations. The database could register trainers and HCPs who have been trained in adolescent health by cadre of HCP, levels of care and type of training (pre-service or in-service) received, to ensure that as much as is possible, all health facilities have trained staff in place.

**5.1.3. Develop and implement Quality Assurance and Quality Improvement mechanisms for adolescent health training programmes**

Quality assurance is the process of ensuring that minimum standards or requirements are in place, adhered to and improved on a regular basis. Quality Assurance and Quality Improvement are closely tied with implementation fidelity, certification and accreditation, asking complementary questions such as: Is the quality of the training provided sufficient to bring about the desired changes in knowledge, attitudes and practices of HCPs? Is the content of the training sufficient to develop the competencies necessary for quality provision of adolescent health services?

Another component of quality assurance/improvement relates to the overall approach that HCPs take towards

their service provision. For example, if facility managers receive adolescent health and or AYFHS-focused in-service training, one of the main components of their training should include processes through which managers can check and ensure the quality of both training and service provision. Setting up quality assurance/improvement systems at the facility level does not have to be an adolescent health or AYFHS-specific task but, in many cases, working towards achieving AYFHS standards should benefit the facility more widely.

Ideally, stakeholders will want to link improved training provision with improved service provision and improved client satisfaction.<sup>38</sup> **Therefore, the M&E framework should be complemented by operational research/ implementation science to be able to identify:**

- What effect did the training have on trainee and health provider competencies?
- What effect did provider competency have on adolescents' satisfaction with services provided and use of services?

## 5.2. Engage adolescents and young people meaningfully in the process of strengthening adolescent health in training programmes for health-care providers

There are many concrete ways to meaningfully engage adolescents and youth in the development and implementation of CBE on adolescent health: being involved in advocacy efforts and in the development

and adaptation of training materials; assisting with the implementation of training as expert patients or providing feedback to trainees, and participating in monitoring and evaluation efforts as anonymous clients or interviewing young users of health services to obtain their feedback.

Meaningful involvement requires appropriate and ethically correct opportunities to participate in decisions about a proposed plan or activity that will affect them (which requires decision makers to seek the involvement of those people who will potentially be affected); and that all of their concerns be considered in the decision-making processes. Potential steps to meaningfully engage adolescents and young people are presented in the [Annex 1](#).

### **Some points to take into consideration when engaging AYP within the process include:**

- One cannot expect the view of all AYPs to be represented by individual representatives;
- Importance of engaging with organizations and networks of adolescents and young people;
- Power, authority structures and training or health outcomes will not change overnight only because an AYP representative is included in the process. Adults require training and support to work effectively with AYP; and
- Cultural, religious, and institutional norms around adolescence/youth and engagement with adults or professionals/providers cannot be changed only by improving the involvement of adolescents and youth in training programmes.



© UNFPA ESARO/Chiara Frisone

# Annex 1. Tools, Checklists and Guiding Questionnaires for Situation Analysis

The contents of the Annex have been included to provide support, structure and ideas for the operationalization of Section 1 of the Guidance: *Key Priority Areas*.

## 1.1. Matrix and Questionnaire to assist the mapping of key stakeholders

SECTOR/TYPE OF STAKEHOLDERS	INPUTS/PROCESSES	OUTPUTS	OUTCOMES
<b>Government</b>	1. 2. 3.		
<b>Educational/ Training institutions</b>	1. 2. 3.		
<b>Private service delivery sector</b>	1. 2. 3.		
<b>Donors/ Development partners</b>	1. 2. 3.		
<b>Civil society/ NGOs</b>	1. 2. 3.		

## 1.2. Questions to support the identification and assessment of key stakeholders

- Who are the key stakeholders involved with workforce development and health systems strengthening?
- Who are the key actors involved in adolescent health in the country/region/facility?
- What are their roles?
- What resources are available to them to support the processes of strengthening adolescent health in competency-based pre- and in-service training for HCPs?
- Who are the leading person(s) or institution(s) for adolescent health?
- Does this person(s) or institution(s) have the necessary authority to support changes in pre- and in-service training?
- What resources will the person(s) or institution(s) require to lead the process?
- What policies, guidance and standards exist on adolescent health and workforce development?
- Which policies and guidelines support integration of adolescent health in pre- and in-service training?
- Who are the key actors/stakeholders that can support the integration of adolescent health in pre- and in-service training?
- Are there multi-stakeholder/multisectoral collaboration structures or bodies that can support this process of integrating adolescent health in existing pre- and in-service training of HCPs?

### 1.3. Questions to help clarify the structure of adolescent health responsibilities within the Ministry of Health and other sectors

1. Is it located in a single department or across departments within the ministry?
2. Is there a recognized and established unit or focal person with a mandate to focus on adolescent health?
3. Is there an individual or group of individuals championing adolescent health at MOH and or MoHE? Who are these individuals and what is their seniority?
4. Which department is responsible for MNCAH/SRHR/ HIV and technical level (ministry and institutions)?
5. Which department is responsible for nursing, doctors, midwifery and/or clinical officers, counsellor/social workers and community health worker's education, including curriculum review?
6. What other relevant departments could play a role in leadership and management of adolescent health, e.g. a department responsible for human resources and/or continuous professional education?

### 1.4. Questions to support the review of adolescent health training for HCPs

1. Is there research on barriers to adolescent and youth health, provision and access of services, coverage and quality of services?
2. What is the situation of adolescent health in pre- and in-service training?
3. How many (and which) institutions are involved in pre- and in-service training?
4. What type of training (pre- and in-service) on adolescent health currently exists (if any) for different cadres of HCPs?
5. What needs to be done to strengthen adolescent health in pre- and in-service training?
6. Is there a plan of action in place for training in adolescent health?
7. What are the available human resources for training (list of trainers, trainer competency assessments, etc.)?
8. How do pre- and in-service training differ in the context you are working in?
9. Are materials available and if so, how much do existing materials need to be adapted to include adolescent health in pre- and in-service training?
10. Are any new materials or training resources needed?
11. Are there any national goals and targets for adolescent health in terms of service provision?
12. What are the key resources that are needed (who/what/where/when)?
13. Which best practice materials/curricula should be applied in specific contexts?

### 1.5. Questions to support the review of training programmes and materials for competency-based education on adolescent health in pre- and in-service training, and CPD

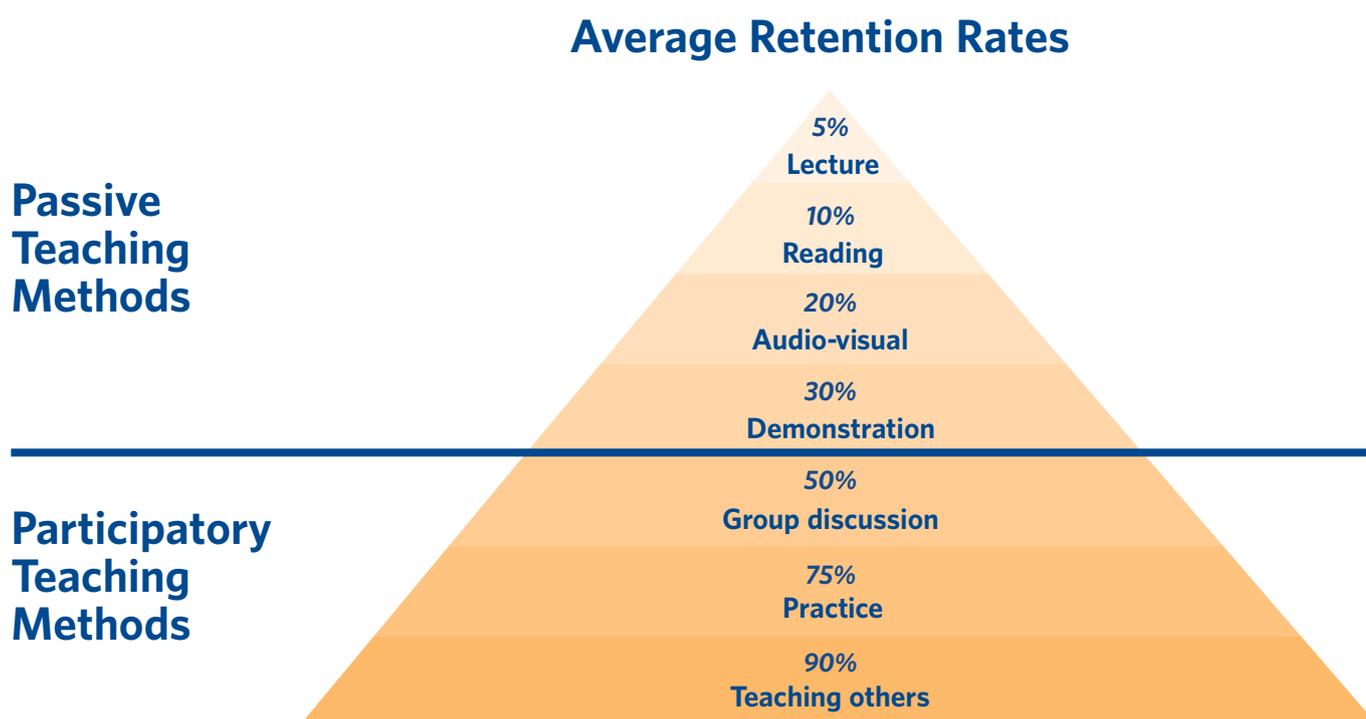
1. Have you developed or can you access existing competency-based training curricula and training materials for adolescent health?
2. Does content match the specific roles and expected competencies of the HCPs and/or facility staff being trained?
3. Do the curricula and training materials apply adult learning methodologies?
4. Pre-service: Do training materials take into account that the trainees may be adolescents and young people themselves?
5. In-service: Do curricula and training materials include supervision and mentoring post-training to reinforce training content?
6. Is there a system in place to track:
  - Adolescent health in pre-service training?
  - Adolescent health in in-service training?
  - Trainers who can provide competency-based training on adolescent health?
7. What is the process for accreditation and certification?

## 1.6. Questions to support the development of an action plan for strengthening adolescent health in training programmes

1. Does the action plan include different goals and aims for pre- and in-service training (both continuing professional development and on-the-job training)?
2. Are there relatively easy gains as well as long-term targets?
3. Are there clear logical frameworks linking inputs (resources), outputs (activities) and expected outcomes (trained HCPs)?
4. Is the timeline of the action plan realistic?
5. Are all outcomes achievable and measurable?
6. Have key stakeholders reviewed and provided feedback on the action plan?
7. Is there a review process embedded in the timeline of the plan, and a monitoring and evaluation framework?
8. Are the activities costed and are resources available to support the implementation of the plan?
9. Is it clear and explicit how young people will be involved?

## 1.7. Developing CBE on adolescent health for HCPs

### The Learning Pyramid\*



\* Adapted from National Training Laboratories, Bethel, Maines.<sup>39</sup>

There is considerable evidence to support the effectiveness of multiple interactive teaching methods, such as case-based methodologies and clinical simulations, which provide opportunities for practical, real-life application of the training content. Multiple exposures to the information, rather than a single “one-off” lesson or training course, are critical to effective learning. This can be reinforced with mentoring and periodic guided facilitation, either in person or via distance ICT-supported methods, such as vetted mobile text messages or SMSs and monitored WhatsApp groups. These methodologies lend themselves to continuous professional development (CPD) and quality assurance/improvement approaches. The methodologies used will have implications for the resources needed for developing HCP competencies in adolescent health.

## 1.8. EuTEACH modules

### SPECIFIC THEMES

**B1. Growth and puberty**

**B2. Male adolescent health**

**B3. Sexual and reproductive health**

**B4. Common medical conditions of adolescence**

**B5. Chronic conditions**

**B6. Mental health**

**B7. Eating disorders**

**B8. Substance use and misuse**

**B9. Injuries and violence, including accidents, self harm, abuse, etc.**

**B10. Functional disorders**

**B11 Adolescents, internet and ICTs**

**B12 Nutrition, exercise and obesity**

### PUBLIC HEALTH THEMES

**C1. Overview of adolescent health: Epidemiology and priorities**

**C2. Public health as applied to young people aged 10 to 19 years**

**C3. Advocacy for the health of young people aged 10 to 19 years**

**C4. Health education and promotion, including school health**

**C5. Youth friendly health services**

### OTHER THEMES

**D1. Training of trainers in adolescent health**

Available at: <https://www.unil.ch/euteach/home/menuinst/what-to-teach/euteach-modules-1.html>

## 1.9. Steps to support the meaningful involvement of young people:

### National level

- Partnership between adolescent health focal points/MOH and grassroots adolescent/youth organizations
- Student representatives from medical/nursing/midwifery included in working group/ coordinating body for AYFHS training programmes
- Adolescent/youth representatives involved in training of trainers and educators from educational institutions; involvement in development of training materials, policies, and standards, and providing views of their peers and their specific needs

### Provincial/ District level

- Adolescent/youth representative in provincial level coordination bodies
- Adolescents and youth trained as trainers for in-service session provision at facility-level

### Facility level

- Peer educators participate in multi-disciplinary team meetings
- Adolescents and youth trained to facilitate case studies or participatory sessions with providers at facilities
- Exit interviews with adolescent/youth patients conducted every year to check/improve on competencies of providers

# Annex 2. Promising Practices

## 2.1. Strengthening coordination and collaboration: the Society for Adolescent Health, Uganda

### Promising Practice: Starting a National Society for Adolescent Health – Uganda

The Society of Adolescent Health in Uganda (SAHU) was started in November 2012 “to promote comprehensive adolescent health, growth and development in Uganda through knowledge dissemination, research, advocacy and affiliation with other societies and bodies involved in adolescent health.” In four years (2012-2016), it has become a well-established and promising practice in building a multi-stakeholder partnership to advance the focus on Adolescent Health in Uganda. It uses a mix of technology and varied learning methodologies to expand and share the evidence on Adolescent Health issues for empowering health-care providers as both trainees and trainers in pre-service and in-service settings. SAHU produces regular newsletters featuring case studies for a growing readership. Case studies are generally locally written, peer-reviewed articles covering topics from adolescent sexual and reproductive health to oral health. Through SAHU partner organization Makerere University, there is now a dedicated adolescent health clinic on campus that allows lecturers, medical and nursing students, and health-care providers “hands-on” exposure to youth clients in a supervised clinical setting. Data on clients is confidentially gathered and maintained. Feedback from clients is obtained with each visit. This data and feedback are used to refine the training and improve service quality.

#### Ingredients for Success of SAHU

- A dedicated champion with a driving vision
- An experienced sister university abroad with whom to partner
- An engaged core group of founding members
- A multi-stakeholder partnership across a broad membership of academic institutions, clinics, clinical research entities, NGOs, FBOs, etc.
- Direct participation by youth
- Continual sharing and building of the evidence base for Adolescent Health in the national context
- Linkages with international experiences and best practices
- Uses a variety of achievable techniques such as guest lectures, informative newsletters based on case studies, Facebook, website, blogs, locally written peer-reviewed articles, mailing lists, and adolescent-dedicated clinic for HCP exposure to youth clients
- Data and client feedback used in quality improvements for training and for service delivery



## 2.2. Promising Practices: Youth-Driven AYFHS Involvement, evidence from the LINK UP Project and P2Z

### International AIDS Alliance – Link Up project

Link Up is a project implemented by the International AIDS Alliance and a consortium of partners, which has engaged over 940,000 young people in Bangladesh, Burundi, Ethiopia, Myanmar and Uganda. The project built a cadre of 10,500 youth leaders, peer educators and role models. Link Up succeeded in building an integrated collaborative project that included youth to improve the delivery of AYFHS in-service training. In three years (2013-2016), Link Up trained more than 3,500 providers on AYFHS. A key element of Link Up is a set of strategies for meaningful youth engagement, including an assessment checklist for partners working with youth.

### Paediatric AIDS Treatment for Africa – Peer2Zero Forum

Another promising practice of a youth-centred, partnership-focused institutionalization of AYFHS in in-service training comes from the Paediatric AIDS Treatment for Africa (PATA). The NGO PATA supports multi-disciplinary clinic-based health teams in 23 sub-Saharan African countries to provide quality health services to paediatric HIV patients, their families, and communities. Two important components to this practice are: (1) the Peer2Zero facility-based relationship, and (2) the interactive youth forum.

In 2016, as part of the Peer2Zero Forum, PATA brought together 72 facility-based HIV-positive youth peer supporters (18-25 years old), 28 peer supporter supervisors and five representatives of national networks of youth living with HIV from five ESA countries: Democratic Republic of Congo, Ethiopia, Malawi, United Republic of Tanzania, Uganda, Zambia and Zimbabwe. The Forum released a statement by the youth peer educators, known as the Dar es Salaam Peer Supporter Declaration.

**The Declaration has powerful messages around engaging with young people in the process of institutionalizing AYFHS in training programmes for health-care providers: Our voices count and must be heard!**

- Don't lecture us! Empower us!
- We insist on access for all, as we are! As young people, we are not all the same!
- AYFHS should happen engaging with young people as clients, peer educators, and colleagues!

The Forum was a prime example of a genuine, meaningful, and non-tokenistic avenue to giving voices to young people affected by HIV. Those attending were peer supporters and their facility-based supervisors – usually a health-care provider with a practical role in AYFHS. The Forum showcased an effective low-resource partnership, built with the goal of mitigating potential barriers through dialogue between HCPs and peer supporters. The growing level of organizing among youth in the region, in the form of national networks of youth living with HIV, was also visible at the Forum. These networks create platforms that empower youth to contribute to developing, implementing, monitoring, and evaluating services for adolescents and youth. Although focused on HIV-positive or HIV-affected youth, these platforms offer a unique opportunity to leverage HIV-specific work to improve the quality of health services for adolescents and youth in the region.

**At the facility level, this partnership has translated into productive working relationships between young peer educators and senior facility management, resulting in improved delivery of AYFHS by institutionalizing young people's involvement in in-service training. Each peer educator's work is tailored to the needs of the context, and may include:**

- Refresher training on AYFHS-related topics for facility staff and the community;
- Mystery client assessment of quality and youth friendliness of services delivered in facilities;
- Developing and disseminating educational materials; and
- Advocating for changes to service provision.

# REFERENCES

- <sup>1</sup> SADC Minimum Standards for Child, Adolescent, HIV, TB and Malaria Continuum of Care and Support. (2013-2017)
- <sup>2</sup> Modified and contextualized from [http://en.wikipedia.org/wiki/Rights-based\\_approach\\_to\\_development](http://en.wikipedia.org/wiki/Rights-based_approach_to_development)
- <sup>3</sup> United Nations, Department of Economic and Social Affairs, Population Division (2015). World Population Prospect, 2015 revisionX
- <sup>4</sup> WHO. Global standards for quality health-care services for adolescents, Geneva, World Health Organization. 2015
- <sup>5</sup> WHO. Core competencies in adolescent health and development for primary care providers, including a tool to assess the adolescent health and development component in pre-service education of health-care providers. Geneva, World Health Organization. 2015
- <sup>6</sup> WHO. Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation. Geneva, World Health Organization. 2017
- <sup>7</sup> Africa Union Roadmap on Harnessing the Demographic Dividend through Investments in Youth. African Union, 2017. <https://d3japsmkk00rot.cloudfront.net/wp-content/uploads/2017/02/EN.png>
- <sup>8</sup> Lancet Commissions. May 2016. Our future: a Lancet commission on adolescent health and well-being – [http://dx.doi.org/10.1016/S0140-6736\(16\)00579-1](http://dx.doi.org/10.1016/S0140-6736(16)00579-1) (accessed April 2017)
- <sup>9</sup> [http://youngpeopletoday.net/wp-content/uploads/2016/11/Step-Up-and-Deliver\\_final-Oct-2016.pdf](http://youngpeopletoday.net/wp-content/uploads/2016/11/Step-Up-and-Deliver_final-Oct-2016.pdf)
- <sup>10</sup> Angola, Botswana, Burundi, Comoros, Democratic Republic of Congo, Ethiopia, Kenya, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, South Sudan, Swaziland, Uganda, United Republic of Tanzania, Zambia, Zimbabwe
- <sup>11</sup> UNESCO. 2016. Fulfilling our promise to young people today – Progress review 2013-2015. The Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people. Paris, United Nations Educational, Scientific and Cultural Organization (UNESCO)
- <sup>12</sup> Denno, D.M., Chandra-Mouli, V. & Osman, M. (2012). Reaching youth with out-of-facility HIV and reproductive health services: A systematic review. *Journal of Adolescent Health*, 51:106-121
- <sup>13</sup> UNESCO. 2016. Fulfilling our promise to young people today – Progress review 2013-2015. The Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people. Paris, United Nations Educational, Scientific and Cultural Organization (UNESCO)
- <sup>14</sup> United Nations Population Fund East and Southern Africa & International Planned Parenthood Federation Africa Region (forthcoming), Assessment of Adolescents and Youth-Friendly Health Service Delivery in the East and Southern Africa Region. Johannesburg and Nairobi, UNFPA, United Nations Population Fund and IPPF, International Planned Parenthood Federation
- <sup>15</sup> WHO. 2014. Health for the world's adolescents, a second chance in the second decade. Geneva, World Health Organization
- <sup>16</sup> WHO. 2013. Everybody business: Strengthening health systems to improve health outcomes: WHO's framework for action. Geneva, World Health Organisation
- <sup>17</sup> WHO. Global standards for quality health-care services for adolescents, Geneva, World Health Organization. 2015 (see [page4](#) or [page8](#))
- <sup>18</sup> WHO. Core competencies in adolescent health and development for primary care providers, including a tool to assess the adolescent health and development component in pre-service education of health-care providers. Geneva, World Health Organization. 2015 (see [page4](#) or [page8](#))
- <sup>19</sup> WHO. Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation. Geneva, World Health Organization. 2017 (see [page4](#) or [page8](#))
- <sup>20</sup> UNFPA ESARO. Assessing the Institutionalization of Adolescent and Youth Friendly Service Delivery in Pre- and In-service Training institutions for Health-Care Providers in East and Southern Africa. Johannesburg, United Nations Population Fund. 2016 (unpublished)
- <sup>21</sup> UNFPA ESARO. Concurrent processes to inform guidelines for institutionalization of adolescent and youth friendly health services: East and Southern Africa Region. Johannesburg, United Nations Population Fund (unpublished)
- <sup>22</sup> Meaningful youth engagement means involving young people, in all their diversity (including adolescents), in all the decisions that affect their lives, and creating opportunities for them to work in partnership with policy-makers to design, implement, monitor and evaluate policies and programmes that seek to fulfil young people's fundamental rights. This includes promoting youth leadership to plan and carry out initiatives and activities, and assisting them by developing and strengthening their skills. PMNCH and Women Deliver, Advocating for Change for adolescents! Geneva, the Partnership for Maternal, Newborn and Child Health. 2017

- <sup>23</sup> See for example Southern African Development Community (2015): Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region, SADC
- <sup>24</sup> UNESCO. Fulfilling our promise to young people today, 2013-2015 Progress Review: The Eastern and Southern African Ministerial Commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people. Geneva, UNESCO. 2016
- <sup>25</sup> Republic of Zambia. Orientation Programme on Adolescents Health for Health-Care Providers: Facilitators guidelines (year unknown)
- <sup>26</sup> <http://www.ngopulse.org/event/2017/07/12/adolescent-and-youth-health-policy-short-course>
- <sup>27</sup> United Nations Population Fund East and Southern Africa & International Planned Parenthood Federation Africa Region (forthcoming), Assessment of Adolescents and Youth-Friendly Health Service Delivery in the East and Southern Africa Region. Johannesburg and Nairobi, UNFPA, United Nations Population Fund and IPPF, International Planned Parenthood Federation. Johannesburg and Nairobi, UNFPA, United Nations Population Fund and IPPF, International Planned Parenthood Federation. 2017
- <sup>28</sup> WHO. Core competencies in adolescent health and development for primary care providers, including a tool to assess the adolescent health and development component in pre-service education of health-care providers. Geneva, World Health Organization. 2015
- <sup>29</sup> WHO. Core competencies in adolescent health and development for primary care providers, including a tool to assess the adolescent health and development component in pre-service education of health-care providers. Geneva, World Health Organization. 2015
- <sup>30</sup> Many of these skills are relevant to overall health systems strengthening and critical to the achievement of universal healthcare access. However, it is crucial that those who are leading this process are able to apply these skills to the unique needs of adolescents and thus recognize the necessity to ensure adolescent health is appropriately covered in pre- and in-service training programmes
- <sup>31</sup> WHO. Core competencies in adolescent health and development for primary care providers, including a tool to assess the adolescent health and development component in pre-service education of health-care providers. Geneva, World Health Organization. 2015 WHO. Global standards for quality health-care services for adolescents, Geneva, World Health Organization. 2015
- <sup>32</sup> WHO. Health for the World's Adolescents – A second chance in the second decade. Geneva, World Health Organization. 2014
- <sup>33</sup> WHO. Core competencies in adolescent health and development for primary care providers, including a tool to assess the adolescent health and development component in pre-service education of health-care providers. Geneva, World Health Organization. 2015 WHO. Global standards for quality health-care services for adolescents, Geneva, World Health Organization. 2015
- <sup>34</sup> WHO. Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation. Geneva, World Health Organization. 2017
- <sup>35</sup> WHO. Orientation programme on adolescent health for health-care providers. Geneva, World Health Organization; Commonwealth Medical Association Trust and UNICEF. 2006
- <sup>36</sup> Baltag V. Sawyer SM (2016). Quality for adolescents. In: International Handbook on Adolescent Health and Development, pp309-324
- <sup>37</sup> Available at: <https://www.unil.ch/euteach/home/menuinst/what-to-teach/euteach-modules-1.html>
- <sup>38</sup> See for example: <https://www.icrw.org/publications/a-study-to-evaluate-the-effectiveness-of-who-tools/>
- <sup>39</sup> [https://siteresources.worldbank.org/DEVMARKETPLACE/Resources/Handout\\_TheLearningPyramid.pdf](https://siteresources.worldbank.org/DEVMARKETPLACE/Resources/Handout_TheLearningPyramid.pdf)



© UNFPA 2019

United Nations Population Fund  
East and Southern Africa Regional Office  
9 Simba Road / PO Box 2980, Sunninghill, 2191, South Africa  
Tel: +27 11 6035300

Email: [esaro.info@unfpa.org](mailto:esaro.info@unfpa.org)

Website: [esaro.unfpa.org](http://esaro.unfpa.org)

 UNFPA East and Southern Africa Regional office

 @UNFPA\_ESARO