World Vision
health and nutrition

What community-based interventions and approaches are most successful in improving adolescent health in Low and Middle Income Countries (LMICs)?

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Contents

Executive summary 3

Part 1: Introduction and background 5

Part 2: Literature review data results 8

Part 3: Literature analysis 11

1. What community-level interventions are recommended for AH in LMICs? 11

2. What community-level intervention mechanisms have been most successful in promoting healthy behaviour change (uptake of AH services, healthy lifestyles and ASRH) by adolescents (boys and girls)? 22

3. What are success factors and barriers in promoting adolescent sexual and reproductive health behaviours within faith-based settings? 24

Conclusions: gaps and the role of the health sector 26

Annex 1: Bibliography – case study references 28

Annex 2: Bibliography – general references 34

Health-related acronyms / glossary

7-11	7 interventions for mother and 11 for child to ensure age appropriate nutrition leading to good health: see http://www.wvi.org/nutrition/7-11-approach
ANC/PNC	Ante-natal/post-natal care
AH	Adolescent Health
ASRH	Adolescent Sexual and Reproductive Health
CHW/CHV	Community Health Workers/ Community Health Volunteers
EWEC	Every Woman Every Child, a 2010 UN acceleration movement for maternal and child survival: see http://www.everywomaneverychild.org/
GAVI	Gavi, the Vaccine Alliance is a public-private global health partnership founded by the Gates Foundation to increase immunisation in LMIC
HIC	High income countries
HPV	Human papillomavirus, a highly prevalent and often symptomless sexually transmitted infection that causes 99% of cervical cancers.
IEC	Information, education and communication (materials eg. brochures, posters, multimedia)
IYCF	Infant and young child feeding
LMIC	Low and middle income countries
NCD	Non-communicable disease (eg. cancer, diabetes, heart disease)
RTI / STI	RTIs are reproductive tract infections; as such the term only applies to girls or women. Some are caused by STIs (which affect both genders) while others may occur in girls who are not yet sexually active: see http://www.popcouncil.org/uploads/pdfs/frontiers/reports/RTIS_GEP_FINAL1.pdf

Executive summary

The introduction of adolescent health as a priority in the post-2015 agenda highlights the vulnerability of this age group to a set of health risks previously outside the programming focus of MDG-aligned projects. It has been identified that after the 0 – 5 age group where the majority of preventable childhood deaths occur, proportionally the next age group at risk is the adolescent (10 – 18), and that these deaths are occurring more as a result of injury, violence, self-harm and early pregnancy as they are to childhood causes such as malaria, diarrhoea and respiratory infections. The mortality rate due to HIV is also a shifting statistic as children infected from birth survive into their teen years. A hidden indicator in adolescent health monitoring is the outcome of behaviour and habits forged during that time that cause damage and reduced life expectancy in adulthood, including gender-based violence, the longterm results of early pregnancy, under/over nutrition and susceptibility to non-communicable diseases.

This literature review forms part of a series of research for World Vision to understand how best to contribute to the reduction of adolescent mortality and health risk. The review selected 69 relevant case studies from an initial scan of around 120.

The WHO organisation has recently released a framework of goals for adolescent health: ASRH, HIV, Violence and Injury, Mental Health, Physical Activity, Nutrition, Integrated Management of Common Conditions, Substance Use, Tobacco Control, Immunisation. The literature review used this framework along with 'circle of care' approaches – provider led, community-based, peer-led, home/family/culture – to generate recommendations based on current adolescent health practices that might inform choice of approach and model for World Vision in this vital child wellbeing sector. The research addressed three main questions.

1. **What community-based interventions and approaches are most successful in improving adolescent health in Low and Middle Income Countries (LMICs)?**

- **Provider-led interventions** focus on both prevention and treatment with the core function to make services relevant and 'adolescent-friendly'. Many governments in LMIC are partnering effectively with health organisations and the private sector to enhance their approach to adolescent health, in particular reproductive health, diet and substance use choices and HIV reduction. Challenges exist in the hesitation of adolescents to consult medical services because of shyness, embarrassment or lack of awareness, and on the other side with medical and health workers who know little about the requirements of this age group and can even judge or stigmatise girls and boys who are in need of sensitive and practical support.

- **Community-based adolescent health programmes** are happening in and outside schools, with youth drop-in centres a highly utilised mechanism for focusing the attention of this age group on healthy choices. Curriculum on life skills including sexual and reproductive health is widely available and, so long as children stay at school long enough, they are likely to receive at least the basics of sex education. The literature shows the value of starting early, possibly even pre-teen, on issues such as menstrual health, RTIs and the physical dangers of early pregnancy, followed by behaviour change and life skills information at an age where it is more relevant. This has helped girls in particular remain in control and able to plan their short to medium term future. On the other hand, health projects specific to adolescent boys are under-represented and primarily focused on reducing STI/HIV rather than offering a full package of support to puberty and young adulthood.

- **Peer-led initiatives** can be considered essential components to adolescent health programming, particularly for raising relevant topics and bringing about behaviour change. However, the literature consistently highlights the importance of holistic programming with peer influence one part of the whole. Adult mentorship in some cases is more effective because adults are more knowledgeable and experienced in sexual and reproductive health. Undoubtedly the existence of peer-led projects is beneficial for the peer educators who receive specific information and training which builds their confidence to interact and advise in the community more broadly. To ensure benefits in target adolescent groups, peer educators must be supported with strong referral networks to specialised adolescent services. A rapid turnover rate and the need to retrain regularly also challenges the sustainability of peer projects, though some have managed to convert this into an advantage with an annual change of peer

leaders in the design.

- **Home, family and culture** play a significant role in guiding children safely through their adolescent years. By including parents in sexual and reproductive health or other life skills courses, projects are improving intergenerational communication and the accuracy and consistency of knowledge on a variety of technical topics. Studies reiterate the importance of behaviour and culture change around an adolescent in order to achieve this. Both boys and girls can face pressure to make negative health choices such as early marriage, substance use or poor nutrition condoned by family and society. In the worst cases, for instance kidnapping for marriage or FGM, no choice is made by the adolescent at all; preventing these harmful cultural practices calls for specialised intervention.

2. What community-level intervention mechanisms have been most successful in promoting healthy behaviour change (as an interdependent association with medical health interventions)?

Behaviour change was inherent in all included reviews and some projects aimed only for behaviour change. Interestingly, the more a project focused on behaviour change, the less technical to the health sector it needed to be. Highlights of effective promotion of behaviour change for adolescents included public/media marketing and messaging, incorporating health into livelihoods programming for out-of-school youth, models that reduce gender-based violence (in particular, Stepping Stones) and projects enabling faith groups or youth groups that focused on self esteem, aspiration and leadership to encourage positive personal outlooks in young people.

3. What are success factors and barriers in promoting adolescent sexual and reproductive health behaviours within faith-based settings?

The literature shows that, far from being a controversial partnership, the relationship between faith groups and the adolescent health agenda is thriving and effective. The HIV and AIDS era has brought many issues of abstinence and fidelity in adults to the forefront of faith leadership and simplified the pathway to discussing similar issues with adolescents. Though not all faith leaders engage to the same extent on open discussions of sexual activity before marriage, many are working with youth and their parents to create better home-based communication and trust, or providing resources for youth groups and drop-in centres where information can be found as needed. Some restrictions and stigma are still apparent, and the male domination of faith leadership is found to challenge the sensitivities necessary to working with girls on issues of early marriage, reproductive health and reducing gender-based violence. A core focus for NGOs is sensitisation and training of faith leaders so that they are ready to seek behaviour change within their sphere of influence. Also noted in literature is the substantial private sector stakehold of faith institutions in health services. Examples exist of successful advocacy to church councils on improving adolescent-friendly facilities and staff. More can be done in this regard and the potential for reach is significant.

Conclusions

The results of this review demonstrate that adolescent health interventions fall across areas of programming requiring many different specialisations beyond health: for instance education, life skills and leadership, peacebuilding and gender empowerment. At the same time, the literature suggests there are gaps in capacities and programming that continue to require the technical specialisation of medical and public health experts. Six key areas where World Vision and partners could apply their health resources to good effect are:

- Support and services for unmarried adolescent pregnancy
- Adolescent health that acknowledges the specific needs of boys
- Menstrual hygiene awareness and resources (in partnership with WASH)
- Supporting the expansion of HPV vaccine; exploring ideas for health checkups integrated with HPV vaccination schedules
- Developing adolescent-friendly services for girls who have married early
- Technical support to faith-based organisations

Part 1: Introduction and background

The purpose of this literature review is to help inform the development of WVI GC Health, HIV and Nutrition guidance to NOs so that adolescent health programming can be based on evidence, best practice and is aligned to World Vision's ministry and reproductive health policy. As such, it aims to identify what is already happening, including strengths in models and partnerships and opportunities for World Vision to engage in the sector. It considers both policy and practice.

Specifically, the review aims to answer the research question:

"What community-based interventions and approaches are most successful in improving adolescent health in Low and Middle Income Countries (LMICs)?"

The primary focus for literature selection is evidence-based practice built on a solid foundation of research rigour. However a secondary element is included in terms of what *should* be the case given the right conditions, inputs and socio-political priorities. Context is highly relevant to the engagement of adolescents of both genders in programmes for physical and mental health, reproductive health and health crisis resolution. The literature review suggests ways that other adolescent health agencies have overcome barriers to inclusion and take-up of services, but acknowledges specific causal factors that may represent a contextual dependency for success.

The review is taking place in parallel with research on World Vision's current practices and reach in terms of adolescent health programming. The two documents together are intended to form a basis of knowledge and advice for developing adolescent health programming guidelines for the World Vision partnership.

> *The inclusion of adolescent health in the Global Strategy of the Secretary General on Women's and Children's Health, represents an unprecedented opportunity to place adolescent girls and boys in the political map beyond 2015. Ensuring that every adolescent has the knowledge, skills, and opportunities for a healthy, productive life and enjoyment of all human rights is essential for achieving improved health, social justice, gender equality and other development goals.*
>
> EWEC Technical Content draft report on adolescent health March 2015.

Background: why adolescent health, why now?

The Global Strategy for Women's, Children's and Adolescents' Health was introduced and passed at the World Health Assembly in May 2015. The first-time inclusion of a new, vulnerable age group in a transnational policy of this magnitude is highly significant. The largely positive outcomes of global efforts to reach the Millennium Development Goals have also exposed gaps and pockets of poverty-related health obstacles where more must now be done. One of these gaps is the adolescent age group. Indicators used to measure children's health – nutrition, vaccination, mortality – will not build an accurate picture of acceptable health levels in adolescents. Usually active, healthy and inquisitive about life, adolescents face a different set of risks and barriers to health from any other age group, revolving around unmet needs for knowledge, guidance on decisions and access to age-appropriate physical and mental health services.

Adolescent health outreach is a mainstay function of schools, youth groups and sporting groups in high income countries, based on the principle that health is a protection issue for young people. Mitigating health risk in this age group is usually approached through enhancing positive choices and behaviour, not medical intervention.

These community-based, accountable services do not exist to the same extent in LMIC; in addition, children in this age group face significantly more health risk from sociocultural norms, lax protection systems and danger inherent in their immediate environment than their counterparts in HIC.

A comprehensive adolescent health strategy must consider risks for both genders, not limited to how young people interact sexually but also how they care for themselves, value themselves and take responsibility for seeking health support and guidance.

The complex network of health risks for young people places intervention activities outside the traditional health sector, particularly in education but also in participation/protection, WASH and disaster resilience. It also has implications for indicators of progress, results and outcomes as multisectoral approaches strengthen the health and wellbeing of children in this age group. Dual rewards await; firstly, that children in LMIC survive and thrive

during a period of great change and risk in their lives, and secondly, that as young adults they continue to take responsibility for their own health, the health of their partner, spouse or other family members, and eventually the health of their own children.

Adolescent health and mortality goals

Figure 1[1] shows the distribution of mortality rates in children and adolescents, indicating that the safest time of a child's life is between the age of 5 and 10. The increase in the adolescent age group is due to several factors that have not previously been prevalent to the same extent.

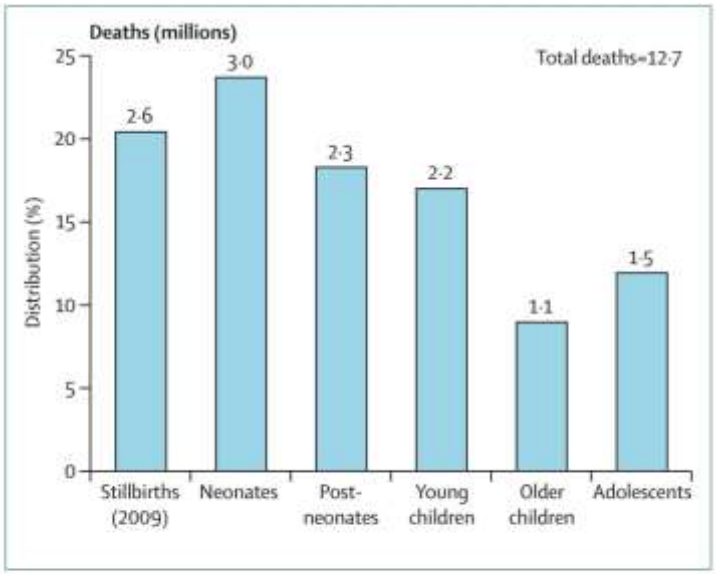


Figure 1 **Age distribution of child and adolescent mortality in low-income and middle-income countries, 2010**
Neonates=day 0 to <28 days. Post-neonates=28 days to <1 year. Young children=1 year to <5 years. Older children=5 years to <10 years. Adolescents=10 years to <20 years. Data from references 21, 34, 142.

According to EWEC[2], an estimated 1.3 million adolescents died in 2012, largely from preventable causes such as accidents, home or street violence, suicide, drug abuse and early pregnancy. Illness through communicable and non-communicable disease (NCD) also represented a proportion of these figures, contained largely to LMIC where diarrhoea and respiratory infection continue to be in the top five killers for children aged 10 – 14. NCD includes risk factors of consumer choice including smoking or poor nutrition leading to obesity, both avoidable if young people understand the significance of these choices for their longterm health and wellbeing.

Data on adolescent mortality indicates that the likelihood of death is higher in older adolescents (15-19yrs) and boys rather than in girls[3]. Girls are bearing the brunt of reproductive health risk, not only in their own choices but also in the beliefs and tolerance of society around them to harmful gender practices (early marriage, FGM) and sexual abuse. As well as contributing to the mortality statistics for the age group, these forms of violence against children manifest life threatening health symptoms later in life such as birth complications and fistula, depression or STI including HIV and AIDS.

In LMIC, recent trends indicate a decrease in the maternal mortality rate (MMR) through improved and focused efforts in regions with the poorest outcomes for maternal mortality using well- established interventions. These efforts have had a particularly positive effect on adolescent mothers who are one of the most vulnerable groups of women of childbearing age. Much of this effort comes from the drive to meet MDG 5, to reduce MMR by three quarters and the most significant reductions have been seen in South East Asia where there has been a decline of 57%, Eastern Mediterranean by 50% and sub-Saharan Africa 37%, however there is still work to be done[4].

Globally maternal deaths in older adolescent girls (15-19) is only surpassed by suicide rates in this group[5]. In response to suicide becoming the leading cause of death in this age group there have been calls for a greater focus on this issue. In every region of the world aside from sub-Saharan Africa, suicide is one of the top three cause of adolescent mortality. In LMIC, lower respiratory tract infections, diarrhoeal disease and meningitis account for 18% of deaths in younger adolescents (10-14yrs), a decline of 1% since 2000[6].

For adolescents in LMIC, particularly in the Africa region, HIV related deaths have been rising. This is despite a downward trend for other population groups. WHO (2012) cites poor targeted service delivery and retention

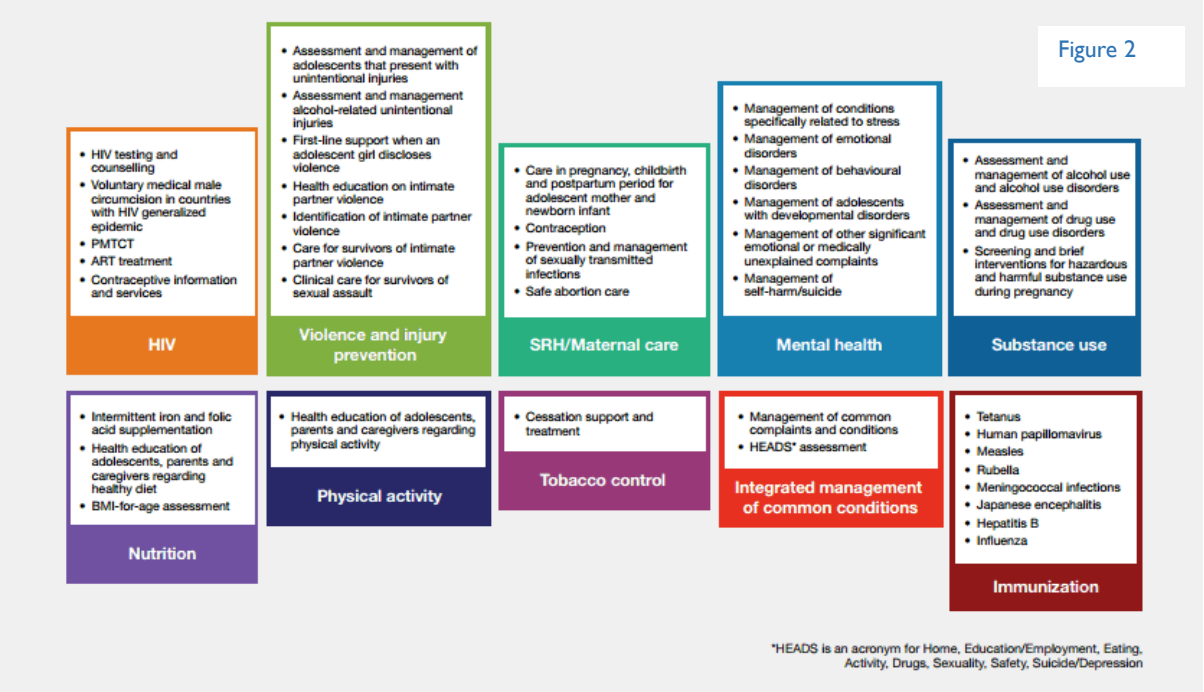
[1] From Global Health 2035 report, p.1911.
[2] EWEC draft research paper: Global Strategy for Women's Children's and Adolescent Health, March 2015
[3] Ibid
[4] WHO, (2014), World Health Statistics 2014. Geneva, World Health Organization
[5] WHO (2014), 'Health for the worlds adolescents- a second chance in the second decade'
[6] ibid

of these services for young people as a key factor.

Interpersonal violence and road traffic accidents are the major killers of older adolescent boys[7].

What can be done?

The 2014 WHO guidelines for adolescent health suggest 10 areas of intervention that together address the risks and causes of poor health and mortality in the adolescent age group. The 10 areas are presented as a framework with clear implications that interdependencies exist between the sectors and that a holistic strategy for the age group is needed (Figure 2).



Unfortunately, this holistic approach to improve the physical and mental health of adolescents is often lacking in the literature around adolescent health. Studies often focus on a single area or programme designed to bring improvements within a specific health indicator, for instance, violence, physical activity, or nutrition. The WHO guidelines are a starting point for a new way of thinking about adolescent health, by gathering successful health and social programmes together in a suite of interventions for full and sustainable results.

Protecting and promoting the health of children in this age group works in a similar way to many other models of empowerment and the 'circle of care' around children as they grow[8].

1. Children themselves are empowered by knowledge, confidence and support to make healthy and health-seeking choices and encourage their peers to do the same.
2. Caregivers and authorities in the sphere of influence for adolescent children take targeted, informed actions to connect children with age-appropriate health services and information.
3. Policies and services for health and nutrition (and more generally for participation and inclusion of the marginalised) articulate and meet the needs of adolescent children.

Working in this way is familiar to World Vision, who uses the concept of the circle of care in education, protection, maternal health and life skills programming. In fact, in a truly holistic model for adolescent health, interventions is likely to intersect with programming in many other sectors of intervention involving young people.

[7] WHO, (2015), 'Youth Violence' - http://www.who.int/mediacentre/factsheets/fs356/en/
[8] For more information: http://www.wvi.org/child-protection/publication/systems-approach-child-protection

Part 2: Literature review data results

This literature review seeks where possible to find examples of integrated and holistic approaches to adolescent health that support children across multiple themes in the WHO guidelines. However, given the gap in studies of programmes of this nature, identification of successful practices connecting a smaller subset of the WHO framework forms the majority of data for the review.

Sharpening the focus

Significant amounts of literature exist on health programming for this age group. To sharpen the focus and ensure a close fit with World Vision's own values, mission and systems, the following definitions have been applied:

- **Adolescent:** World Vision identifies the adolescent age group as between 12 and 18 years old. Though there is some terminology overlap between adolescence and youth, literature on young people who are 18 or over does not apply to this review.
- **Adolescent health:** Adolescent health encompasses many elements, not just Adolescent Sexual and Reproductive Health (ASRH). The review draws on literature across the scope with particular interest in interventions that promote and measure holistic adolescent health.
- **Global policy and the WHO adolescent health framework:** World Vision's future adolescent health programming will take guidance from current discussions and conclusions from WHO, EWEC, the SDG post-2015 agenda for adolescents and other relevant policies contributing to the global framework on adolescent health. This study groups practices and concepts using the 10 key interventions in WHO guidelines (include the graphic).
- **Lower to middle income country (LMIC):** The review considers only evidence from LMIC because these contexts are where World Vision's strategic mandate lies. In line with Cochrane guidelines for excluding high income countries (HIC), the difference in resources, social safety nets and child protection between LMIC and HIC means that "the evidence would be unlikely to be transferrable."[9]

Criteria for inclusion

The literature selected for this study meets the following criteria:

- The study is peer reviewed and its findings endorsed.
- The study describes appropriate methodology for its conclusions
- The study fits within the sharpened focus (see previous section) of adolescent health in LMIC aligned with WHO framework
- The study describes a process or practice relevant to World Vision's programming scope (we are not a medical organisation)
- The study describes a model that is, or can be, integrated with other forms of child and adolescent wellbeing in line with World Vision's usual integrated development approach.
- Where the study is 'grey' literature produced by other agencies to inform programmes, original evidence is cited and preferably can be located.

Data results

Around 120 studies on adolescent health were sourced using a variety of keyword searches in databases such as Cochrane, WHO and Elsevier, as well as specific journals including Lancet Health, Lancet Mental Health Lancet, International Perspectives in Psychology, International Journal of Mens' Health and others. Of these, 69 were deemed to meet criteria for inclusion. Several of these were meta reviews lacking specific description on successful models but instead providing robust analysis that helped to shape the narrative of this report. Eight of them were 'borderline'; they had not yet been fully evaluated or the evaluation evidence was not retrievable, but the perspective they brought to the discussion was too valuable to dismiss.

[9] http://epoc.cochrane.org/sites/epoc.cochrane.org/files/uploads/LMIC%20Focus%20Parameters.pdf

Figure 3 uses the WHO framework themes to demonstrate the weighting of inclusions in the review. The majority took a primary focus on ASRH or HIV, though reduction of violence and promotion of adolescent mental health were also important themes in the literature. As almost all projects took a secondary focus on drivers or associated risks in another theme, the number of results in this graph is greater than 69.

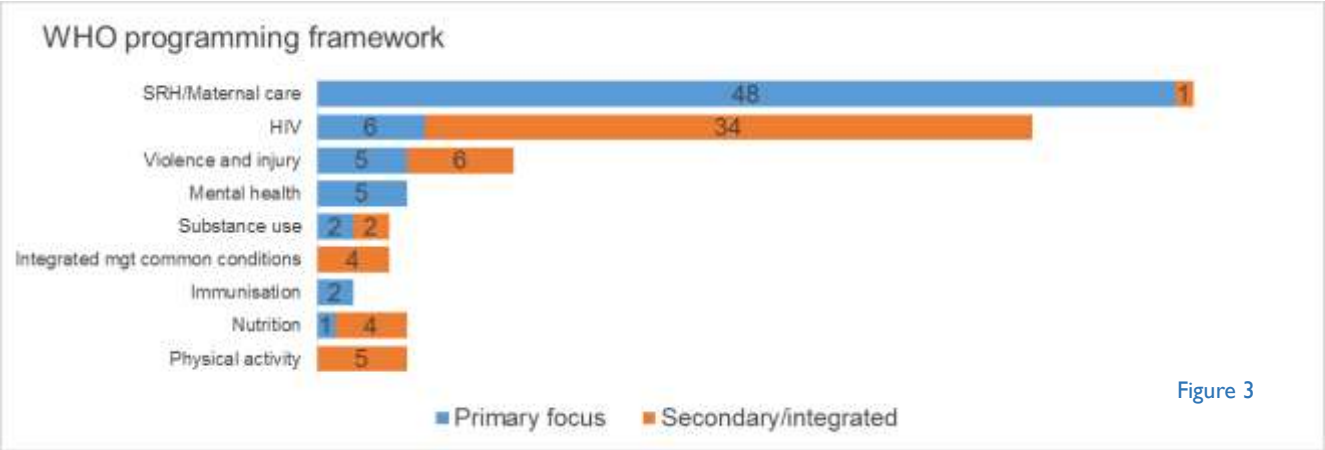


Figure 3

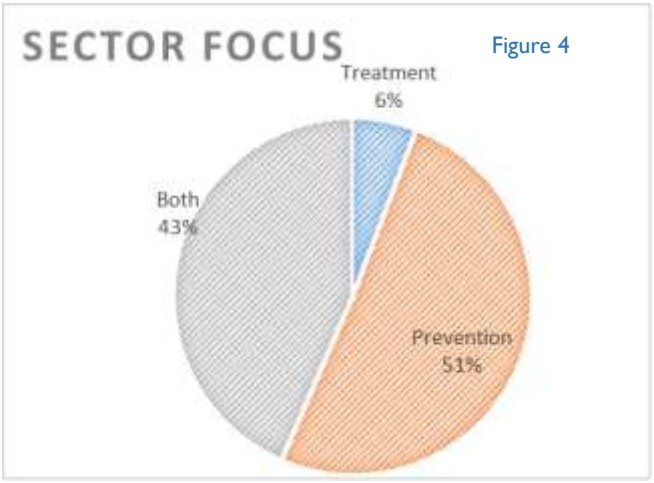


Figure 4

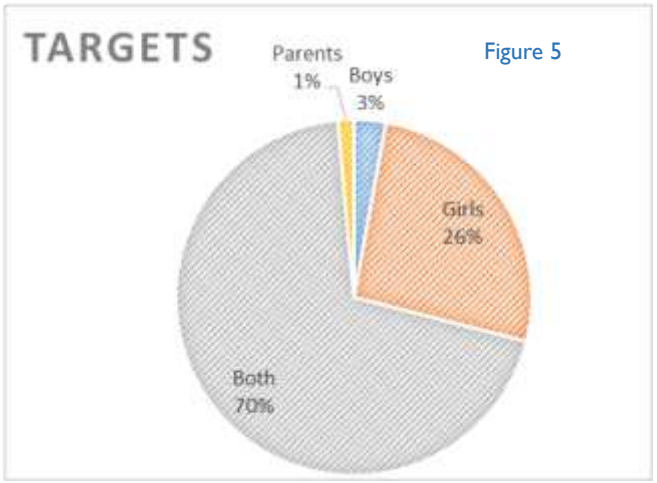


Figure 5

Figure 2 shows the proportion of cases focused on treatment compared to those focused on prevention. A slight majority focused on prevention. However this should not be taken as indication that prevention-only models are the most successful; it is largely due to the HIV 'legacy' inherent in ASRH programming, as the narrative of this review will explain. Figure 3 maps the primary targets of the projects, showing that girl-only projects are significantly more common than boy-only projects. The majority targeted both and two innovative projects were designed specifically for parents.

Figures 4 and 5 show the origin of the research. It favours the African continent, though care was taken to examine all regions to address this balance. There is surprisingly little available on this topic from East Asia; from South Asia, India provides the largest share and is also the country most featured in the reviews (9 cases, or around 13% of total).

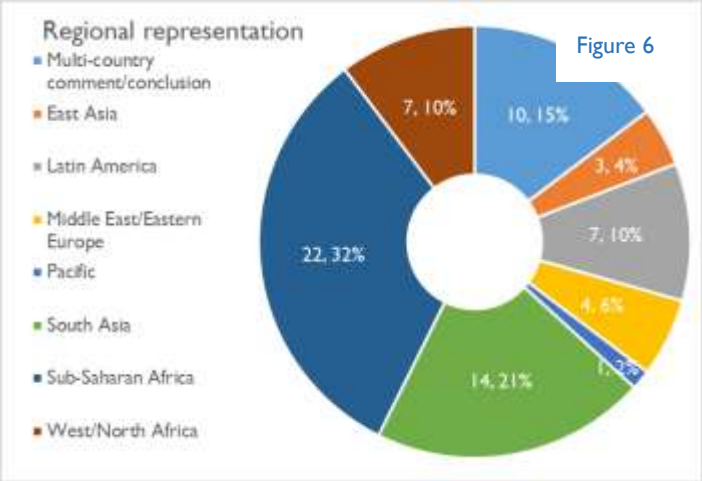


Figure 6

Figure 6 shows where each relevant case predominantly fell in terms of building the circle of care (see intro to research question 1 for the logic behind this). The split was necessary in order to fit with the structure of research narrative which considers effective models and approaches under each category, but it is important to note that selecting just one approach to highlight does not really do justice to complex projects, and in fact for some of the most successful projects was impossible. These have been marked as 'holistic'.

A list of the literature including these filters appears at Annex 1. They have also been used widely as examples to support the discussion in Part 3 of this report.

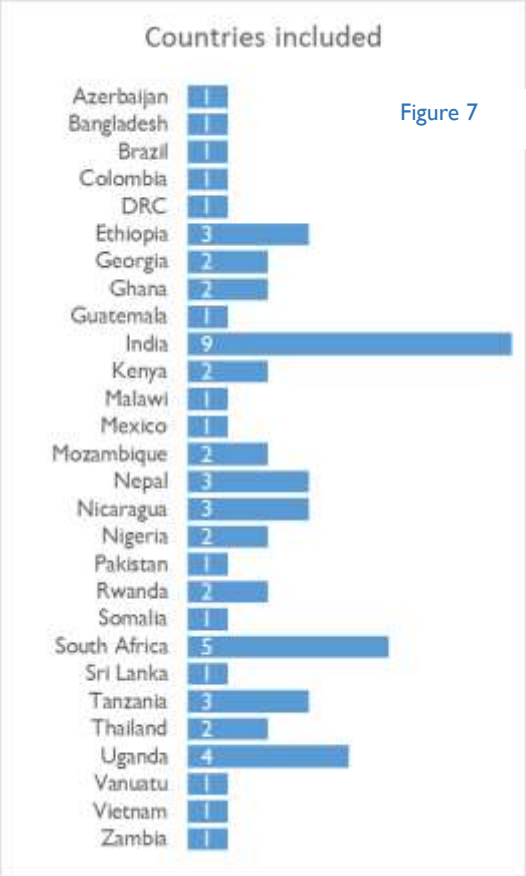


Figure 7

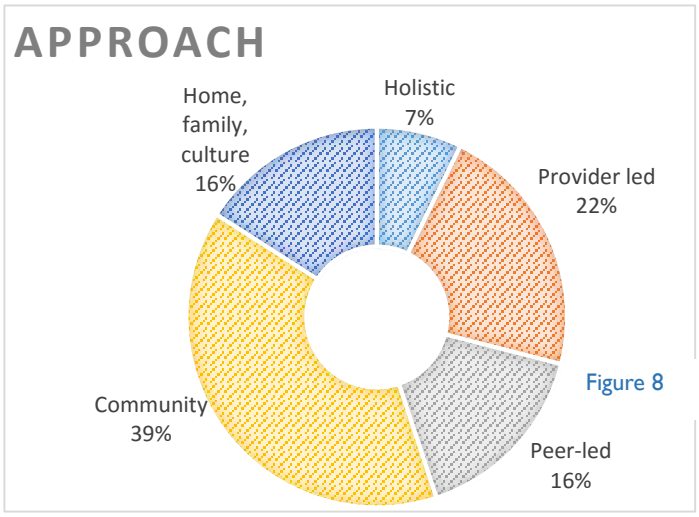


Figure 8

Part 3: Literature analysis

1. What community-level interventions are recommended for AH in LMICs?

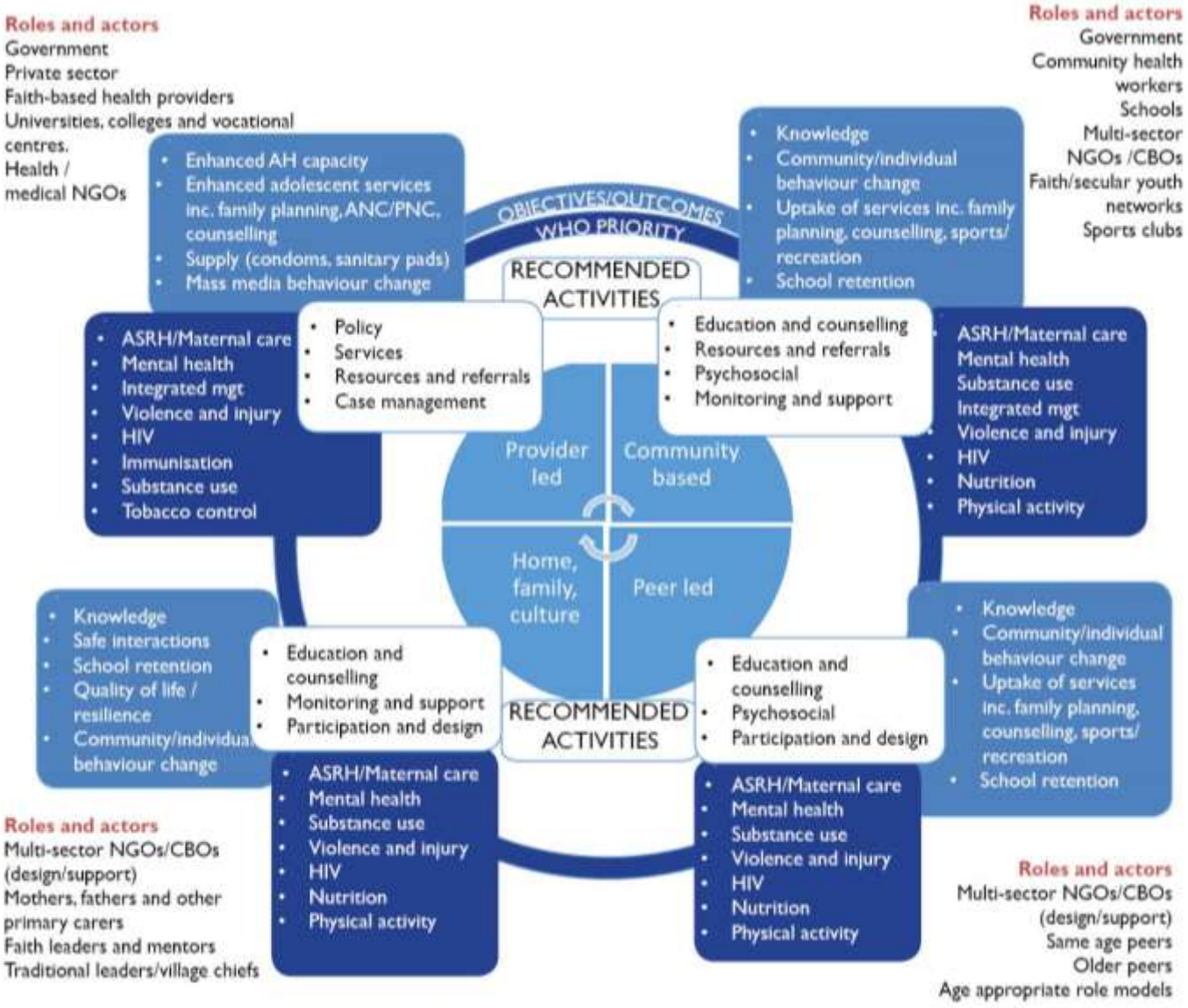
To answer this question, the cases have been grouped to show what is most common, and then compared to identify what is most highly recommended, as follows:

- Firstly the concept of the circle of care was laid against the levels of health intervention NGOs usually consider for U5 survival: provider, community, household. Unique to this age group, peer interventions between children directly form a fourth branch.
- Secondly the cases were mapped to show which of the four branches had been the predominant (though it is important to note that many of the more successful projects were leveraging multiple, or all, approaches).
- From here, the WHO framework priorities were added to determine the main outcome sought by each approach, as well as more specific objectives that would drive results in the WHO priorities.
- Finally, the roles and actors for each case were considered to identify who is working in each approach. The effectiveness of roles is a common theme for meta reviews[10] and for this analysis also; actors are working in the adolescent health space with varying degrees of success and the literature contains valuable insights and comparisons which can be used to improve accountability and effectiveness of civil society in creating the adolescent health 'circle of care'.

Figure 9 (next page) summarises the grouped results based on this analysis, and is followed by overviews of current practice and recommendations in the four approaches: provider led, community-based, peer led and family/home/culture based.

[10] For instance, Koon et al.(2015) on community health workers, ICRW (2014) on peer approaches, HNP (2012) on the faith-based role, WHO 2007 on the role of parents.

Figure 9: Summary of adolescent health approaches in NGO/CBO programming



Provider led

All projects in the review with a provider focus were working in contexts where health and medical systems were found to be insufficiently specialised in the needs of adolescents. The majority were aiming to reduce STIs, HIV and early pregnancy, so fell into the WHO category of sexual reproductive health and maternal care. Improving mental health support for adolescents was another relevant theme, though somewhat lost in the crowd compared to the volume of ARH/HIV objectives. Projects often partnered with appropriate ministries (usually the Ministry of Health but also other relevant bodies such as Ministry of Youth/Ministry of Sports) to create policies and campaigns that would increase not only healthy choices but also uptake of health services when required. Strengthening human resources was a top priority for providers, because greater awareness and consideration of adolescent needs was the first step towards finding ways to fulfil them.

One role for NGOs in partnership with local government is to engage in vocational training of existing health workers so that adolescent health specialisation is more readily available. This is also relevant in the community-based (schools, youth centres) and home-based (community health workers) discussions later in the paper. As well as physical conditions including SRH, building skills in working with adolescents also applies to mental health.. WHO found when researching psychosocial support to HIV positive adolescents that psychologists and counsellors are avoiding the age group because they are not confident of their skills or, burnt out, feel it is 'too hard' (WHO 2009). WHO also offers a variety of toolkits to help NGOs upskill health workers to ask the right questions and give age-appropriate, tactful answers when talking to adolescents about their health. Evaluation of results from these toolkits was not located; however, several cases included in the review confirm the value of similar approaches (on mental health, Weiss et al. 2012; on CHW, Pathfinder 2006; on pharmacists and maternal care workers, USAID 2009).

Studies reiterate the importance of addressing both supply and demand in order to achieve desired health outcomes. Improving services in isolation of addressing adolescent hesitation to use them is poor strategy. Woog et al.'s meta review of barriers to girls' health-seeking (Woog et al. 2014) indicates that many girls avoid medical facilities due to the lack of friendly, experienced and discreet youth health mentors within a clinical environment. The regular 'family' doctor is likely to consider and treat adolescent girls as sexually inactive, including withholding family planning expertise she or he might share with an older or married woman. A particularly dangerous time for adolescent girls is post-abortion, because the procedure so often happens outside the medical system and the girl is frightened to come forward for treatment, checkup or contraception counselling. Antenatal care for adolescent mothers was another priority area for provider led initiatives, particularly in improving policies (local/national) for creating adolescent specialisations and reducing stigma within the medical workplace against young unmarried mothers.

While improving youth-friendly services is an important strategy, Woog et al. also see media messaging as key, citing a successful text campaign in Mozambique which combined storytelling with facts and a call-back hotline (Evidence to Action 2015). The project also produced a radio soap opera to promote subscription to the text campaign. This increased knowledge and delayed sexual debut, but did not see significantly more clinical requests for contraception. Media and public health campaigns are discussed in more detail in the behaviour change section of this report.

A model that has worked well in drawing girls and young women to clinics is clinic vouchers (Woog et al. 2014, Grainger 2014). In Nicaragua, the voucher system led to doubled use of contraceptives among adolescent girls using the voucher, and user satisfaction with the health system was significantly higher. Doctors also reported that the information on the voucher helped them to provide age-appropriate advice and care. In Uganda, the government scaled the model after pilot results showed strong responses in accessing and using family planning methods[11]. The World Bank trialled cash transfers in Malawi, some conditional to reduce school dropout as a driver of early pregnancy and some unconditional to allow access by girls outside the school system. Results concluded that while the conditional cash transfer had a larger impact on school enrolment and English reading comprehension, the unconditional cash transfer had a substantially larger impact on reducing teenage pregnancy and marriage (ICRW 2014).

[11] Note that the Uganda model was not specifically for adolescents.

Highlights

- **Advisory hotlines**

Marie Stopes International operates a unique model of affordable for-profit family planning clinics that ensure sustainability and growth of facilities for girls and women throughout LMIC. Recognising the challenge of attracting adolescent girls to a clinic that is specific to family planning, the organisation introduced interactive advisory services that could be accessed by mobile (in South Africa) or by website (in Pakistan). Girls could look at or receive pre-programmed answers to frequently asked questions, or ask to talk/email directly with a medical professional. If necessary, and with the girls' agreement, an appointment would be made at the nearest Marie Stopes facility. The advisory services saw a greater number of adolescents using facilities, though no specific research was done on knowledge rates among girls who used the hotline but did not attend. (Marie Stopes International 2012)

- **Mobile clinics**

An ICRW study across 3 contexts (Tanzania, Zimbabwe, Thailand) found that 16 to 32 year olds used mobile clinics to access to HIV testing and counselling three to 10 times more often than brick-and-mortar facilities. It was not stated whether this was to do with the convenience, the reminder of the importance of health checkups, or the inability to put off visiting for the next day (ICRW 2014). Another project in Colombia delivered by ARC had permanent clinics but provided mobile outreach for different geographic areas. The service including transport to the clinic, was timed for before/after school so that adolescents could attend more easily. Adolescents helped to design the clinic layout, ensuring it would appeal to others in their age group (WRC 2012).

- **HPV immunisation policy**

Immunisation in developing countries is heavily dependent on supply and policy, and therefore cannot be the exclusive remit of international programming. However, it is worth noting two 'borderline' inclusions in the literature review on this topic. DPT, measles, polio and other childhood immunisation programmes occur earlier in life and single dose rubella is due at around the age of eight. For adolescents, the GAVI/WHO focus is on HPV, the cause of cervical cancer in over 99% of cases. HPV immunisation benefits both boys and girls but considering limited resources in LMIC, policy has focused on girls. Nwadoni & Palmieri (2014) make strong recommendations for using schools as a collection point for free immunisation, citing the case of Brazil which currently has 85% coverage, higher than some HIC. Macphail et al. (2013) agree but suggest further that the introduction of HPV vaccination into schools represents a strong opportunity for broader health checking, sensitisation, counselling and advisory services at a time when girls could benefit significantly from this compulsory, free service. While the researchers do not yet have examples to share, the analysis makes a strong argument for further development of integrated health management along these lines.

Community led

Few adolescent health interventions in the community do **not** have sexual and reproductive health among their goals. The 'classic' SRH prevention model, as a legacy of decades of HIV programming, is broadly promoted in the literature. It is usually school-based or club-based, and uses either a specific curriculum or ongoing mobilisation and awareness raising among young people so that vulnerable adolescents are aware of their choices and what constitutes risky behaviour. There is good logic in converting the familiar 'ABC'/Life Skills package to meet the broader needs of sexual decision making for young people. Even in contexts with low HIV prevalence, the risk of infection and longterm effects of certain STIs, as well as the WHO global priority for delaying first pregnancy, merits the urgent provision of knowledge and choice for young people. Some literature questions whether the positive and participative life skills model is not somewhat 'preaching to the converted', in particular those based in schools which automatically exclude the most vulnerable out-of-school adolescents (eg. ICRW 2014: 23, WRC 2012) . As well, the standard knowledge and mobilisation approach fails to adequately address many of the drivers of risky behaviour which extend beyond choice into issue of gender (and gender violence), low employment opportunity, masculine stereotypes and peer pressure, and cultural norms such as early marriage or hiring sex workers.

A massive gap for girls in developing contexts has been knowledge of menstrual health and hygiene and non-sexual RTIs or genital conditions such as candida. This need has given rise to several strong health programmes

for adolescent girls, some starting as young as 8, allowing them time to prepare for puberty before faced with it (eg. ICAI 2012, USAID 2012, ICRW 2014). In the ICRW case from Guatemala, girls' clubs held activities and workshops over several years, with the girls attending different age appropriate sessions as they grew older. Some workshops also involved their mothers. A retrospective evaluation found that 100% of the girls completed primary school[12] and that a higher percentage of girls in the programme remained childless in their teen years compared to non-participants.

Research on the drivers of negative behaviour and health risk-taking in adolescent boys in Durban, South Africa revealed that the best way to protect them was to ensure they attended school (Basterfield 2014). The research makes careful distinction between dropout and absenteeism, and concludes that the school system examined is not doing enough to attract boys to school regularly. School retention has also long been acknowledged as a solution to early pregnancy and marriage in girls (eg. De Neve 2015). Just as with the boys in Durban, some girls stop attending school simply because they do not like it and wish to try something else, including early motherhood. ICRW notes: "While many adolescents, especially married adolescents, experience "wanted" pregnancies, more research is needed to understand the social pressures that encourage girls to express a desire for these early pregnancies." (ICRW 2014: 14). Several positive examples of schools linking with referrals and services through counselling, clubs and clinics are illustrated in the literature (eg. Kesterton 2010, Mathews et al. 2015, CBI in Fazel et al. 2014). Fazel's CBI (classroom-based intervention) for adolescent psychosocial wellbeing has three phases: firstly, a brief screening of students identifies concerns, and children are then invited to participate in a series of group sessions involving play, drawing and discussions. At the conclusion of the programme, a further screening takes place to see who might need referral to more formal counselling. Fazel considers CBI results in a number of settings and is satisfied with the overall benefits of the approach with some contextual reservations; where children have suffered recent community trauma or are displaced, CBI can bring up bad thoughts or memories without the psychosocial skills to directly address them. Another positive mental health model from Vietnam is provided in Weiss et al (2012). A VCMHRTP[13] initiative, its focus is on exponential upskilling in psychosocial support for rapid access and appropriate referrals for at-risk children and adolescents in and out of school. Components for doing so include a graduate programme, a research-focused partner network, a schfrool-based mental health project in partnership with government, teacher training and outreach services in partnership with CBOs. Note that this is a 'borderline' example as it has not yet been evaluated. (Also see section Fragile Contexts for an evidence-based psychosocial 'first aid' model from Gaza.)

Youth clubs, sports clubs and drop-in centres feature extensively in community-based prevention evidence (McLeary-Sills et al. 2011, WHO 2007, WRC 2014, USAID 2012, and several others). A hybrid between the youth centre and the adolescent-friendly facility has been trialled in several contexts (ICRW 2014). Results are mixed. It is suggested that a full drop-in approach can overwhelm the health and counselling functions of the clinic, with older adolescents sometimes taking over and younger (particularly female) no longer attending. The quality of medical advice is also usually limited by the low-cost imperative of running a community facility. However, a well supervised, safe facility where young people can discreetly seek advice or simply come to play and interact can meet with high levels of satisfaction from target adolescents using it (see Mae Sot example, Fragile Contexts). A quality, practical referral component, rather than offering treatment on site, seems to be a recurring factor for success.

A gap in the literature, and possibly in programmes too, is accessibility and understanding for adolescents in regard to treatment. The chain appears to stop at getting a child to a doctor. CBOs for specific adolescent challenges in the treatment phase, for instance helping with the stigma of rape or HIV status in an unmarried girl, the psychological impact of not carrying to term, returning to school after failed pregnancy or as a young mother, are lacking compared to the situation in HIC. The literature also mentions several times the vulnerability of young mothers who are less likely to know about or attend ANC/PNC and who have also increased their risk of reproductive health-associated conditions later in life. This applies not only to unmarried mothers; mothers in early marriages are expected to assume adulthood despite lack of information, education and life skills available to many others their age (see Care Groups for Adolescents under Peer section).

[12] The comparison rate is not provided but the strong implication is that it is less than 100%.
[13] Vietnam Children's Mental Health Research Training Program

Highlights

- **Nutrition and reproductive health for adolescent girls**

An innovative schools programme from USAID in India aimed to reduce risks of reproductive health alongside nutrition in girls aged 11-14. The curriculum emphasised knowledge on early marriage, dangers of early pregnancy and the importance of menstrual hygiene including using disposable pads or washable cloths. IEC materials were also available throughout schools so that boys too could read about these 'girls' issues. The programme tested IEC only against IEC plus a 10 session course. The course included a personal 'health diary' with four sections: My small and beautiful world; What I have learned; What I need to do next; My records (which included records of what they ate each day). The diary was met with extreme enthusiasm, and girls shared what they had written with both parents (fathers were usually making marketing/food diversity decisions). Results in terms of maintaining IFA tablets and taking deworming (government-supplied), going for a health checkup (free), and menstrual/genital hygiene increased in both groups but the results in girls who had taken the course were more than three times those in the poster-only schools.

- **Adolescent-friendly centres as part of the community health network**

The same project in India led a two phase (early/late adolescence) awareness initiative with remarkable statistical achievements for girls and boys in reducing anemia and risky behaviour (USAID 2012). Adolescent friendly centres and health camps attracted in-school and out-of-school adolescents, who were offered both peer and adult support (with stipends for retention of trained AH educators). The project engaged in extensive adult, government and health worker sensitisation, encouraging *anganwadi* workers who felt out of their depth to refer adolescent children to the expertise of the AFCs; this was also more cost-effective than upskilling the health workers directly. The AFCs contained a letterbox for anonymous questions, but shared the answers with everyone via a bulletin board. Individually resolved cases cited include that of a doctor who told an adolescent boy he would need expensive treatment to contain his nocturnal emissions and a girl who believed she was dying when her first period arrived. In both cases, timely referrals to AFC counsellors equipped with materials and knowledge to explain these phenomena helped the young people to understand what was happening to them.

- **Adolescent health within the MNCH framework**

A successful project for "Healthy Women" in Georgia (USAID 2009) articulated an adolescent component as part of the strategy. This included not only life skills, gender equity awareness and early pregnancy/marriage counselling for both genders, but also advocacy to health providers, family planning services and pharmacists to understand and meet adolescent needs without judgment. As the project expanded it worked with internally-displaced and conflict-affected communities using the same principles and approaches. Youth programmes were school-based but out-of-school youth were encouraged to attend; peer educators were re-appointed through schools each year and ran their own programmes, with an annual award for "Best Youth Programme" encouraging sustained interest and innovation. The project, which also increased the involvement of fathers and the quality of ANC/PNC, was deemed extremely effective across its multiple age groups and gender targets.

Peer led

The literature covers peer involvement in adolescent health in good detail including reporting results of two decades' worth of adolescent and youth interventions in HIV. It should be noted that the term 'peer' is used rather loosely. It usually means someone of higher secondary or lower tertiary schooling who has been recruited and trained to take a responsible advisory role for others of their age or younger. However, peer educator models have also been used in the workforce (eg. Bangladesh case study in Marie Stopes International 2012). Peer education, mentorship and role model approaches work to achieve several health-related goals including violence and injury (for instance, disaster risk reduction), ASRH, substance use and mental health (leadership/self esteem). Physical activity while rarely a project goal is often present as a tactic and side benefit. Peer educators do not diagnose or treat, making it essential that peer programmes are happening in conjunction with other community/provider health actors. For instance, a review of 22 school mental health programmes (Barry et al. 2013) showed that peer mentorship was a valued component of such programmes but that core curriculum and counselling was appropriately taken up by trained professionals. Though some youth clubs had sustainability through a governance committee and community fundraising strategies, no peer programme in the review was

stand-alone.

The literature reiterates the enthusiasm and reach of peer educators working in schools, clubs and the community through leaflet drops, street dramas, health fairs and other visible events. This makes results – even slight results – cost effective. Consistently the young people who benefit the most from knowledge and behaviour change in peer led initiatives are the peer educators, who usually receive somewhere between a day's and a month's training, build their own confidence and leadership to advise others, and become recognised and appreciated by children and adults in the community. Several studies highlighted the transience of peer educator involvement which, though sincere, can last two to three years at most and is usually much shorter. Two approaches to mitigating this risk were suggested: stipends (which may not always be possible depending on the donor and model) or 'cascading leadership' with the understanding that an annual cycle of appointment and training is part of the process.

The literature provided examples of successful peer education in HIV prevention and uptake of VCT, awareness of gender issues including early marriage, and even gender-based violence using the Stepping Stones model (see behaviour change section). However there is not full agreement that knowledge leads to action, as most prevention indicators are self-reported. ICRW looked at school-based awareness programmes and concluded that those led by adult mentors were actually more effective than those led by peers. Outside schools and beyond the role of awareness and mobilisation, peer educators are proven to fulfil an important mentoring and referral role for individuals in need of support. From distributing basic contraception to discussion of SRH changes and challenges, these mentor roles are the link between service providers and adolescents who are reticent to use them. Analysis of literature results suggests that the best place to locate this role is in a community drop-in centre or club room operating to regular hours and where a range of resources and services for young people are offered (not SRH/HIV only). This model in Zambia across 9 different 'Youth Friendly Corners' referred 146 pregnant adolescent girls for antenatal care who might otherwise have gone without (AstraZeneca 2014(2)).

Peer contribution to project design and goals, facility 'look and feel' and participatory research adds to the quality and relevance of adolescent health projects (AstraZeneca 2013 (2), African Youth Alliance 2004). For the Vitu Newala ("Newala Youth Can") project in Tanzania, girls aged 18 to 24 were trained as researchers then conducted sessions with younger girls (12 – 17) to identify aspirations and obstacles faced by the current generation. The project used this information to achieve goals of reduced risky behaviour, with the side benefit of increasing girls' confidence to discuss sex and family planning with parents, other adults, friends and potential sexual partners (McCleary-Sills et al. 2011)

The contribution of street drama to adolescent health risk reduction is somewhat cloudy. Almost every peer-led project in the literature reviewed incorporated drama activities and described them as 'successful' but without strong evidence linking behaviour change in adolescents with their exposure to street drama messaging. An exception is the 'Somos Diferentes, Somos Iguales' project in Nicaragua (ICRW 2014: also see behaviour change section) which measured the relative contributions of a mass media campaign including street drama and concluded that the broad range of messaging strategies led to greater reach and saturation – but the study is not specific on whether the dramas were peer-produced or professional.

Highlights

- **What young people want**

A 2004 review of ASRH programming in Ethiopia (USAID 2004) found that youth centres were overly focused on the core mandate of health counselling at the expense of youth-friendly appeal. Adolescents wanted more recreational/sports facilities, more quiet corners, comfortable couches and libraries. Most youth centres offered some sort of recreational activity for young people and many had a small space appointed for reading or studying, but, though better than staying at home, young people and some of the adults associated with the centres stated more could be done in this regard. When a youth centre was too crowded or loud, adolescents felt less welcome and less inclined to join spontaneous or planned activities. Making youth centres less about sex and more about fun, so long as trained peer educators were still accessible when needed, could bring a greater number of adolescents, particularly girls, into the facility.

- **Peer influence in the workplace**

A Pathfinder project in Ghana trained nearly 497 peer educators, 297 of them from school/community groups, and 200 who were already employed in a trade that dealt with young people, for instance, hairdressers, retail or sewing. Their role was to share IEC materials and distribute condoms. At the end of the five project, though there were fewer workplace peer educators than community-based, they had distributed 58% of total condom supply (over 750,000 condoms).

- **Care groups for adolescent mothers**

The Care Group approach is widely used to bring together mothers and their children as a group to discuss and learn about issues common to them. Foremost a maternal/child nutrition intervention, it also aims to improve health, WASH and IYCF practices. In Nigeria, International Medical Corps (IMC) included adolescent girls as a separate group under their Care Group programme. Aged 15 – 19, all the girls participating (over 200 by end of project) were married, most had at least one child, and some had three. Finding and inviting the girls was challenging; community leaders had only a rough idea of who or how many they were, and the project needed to call on existing CHVs to visit households and explain the programme so that the husband's permission could be sought. For these girls, the curriculum was the same as for their adult counterparts, though the group leader was younger. When separated from the adult mothers, whom they didn't know, and towards whom a hierarchy of courtesy was due, the girls found it easier to overcome their shyness and speak in front of other group members. Husbands became supportive on seeing results and some asked for their wives to be included after all.

Home, family, culture

The role of parents and other home-based influences in protecting and promoting adolescent health is pivotal. A safe home where confronting issues are discussed openly is a starting point for self-respect, esteem and confident decision making as children progress through their teenage years. In two of the projects reviewed, achieving this was the project goal, while most of the more effective integrated models had parental mobilisation and changes to community attitude as an output tactic. Many studies noted that barriers to achieving parental mentorship lay in intergenerational misunderstanding, shyness or awkwardness and limited knowledge in parents about the realities and risks of the modern world. The biggest change of all has been the emergence of HIV which forced communities across the world to communicate more effectively about protection during sex but largely left out 'low risk' groups such as parents in a longterm marriage.[14] Remesa et al. (2010) make the point that young people who have grown up in the HIV era probably know more about sex, contraception and STIs than their parents ever did. At the same time they are by no means the first generation to face and take decisions on sex before marriage: the study notes: "Restrictions on young people's sexuality and the expectation that a relationship will include sexual activity also mean that relationships are kept secret from adults, even if these do not involve sex."

In the literature, mothers featured more prominently than fathers as mentors for their children, particularly their daughters. Excellent results were reported when mothers accompanied their daughters to pre-teen/early teen awareness sessions for full and aligned understanding of what lay ahead (ICRW 2014,). For older daughters, mothers attended parallel but separate sex education classes, allowing the opportunity to discuss later at home (Gottschalk 2015, WHO 2007). One project invited mothers to contribute to the curriculum based on what they thought their daughters needed to know, but were unsure how to tell them (Engender/ICRW 2004). These approaches, within a broader spectrum of services and skills for adolescent girls in menstrual hygiene, reproductive health and family planning, were proven to increase the communication and trusted connection between mother and daughter.

Fathers were mentioned less in the literature, mainly in concert with a range of positive male role models (faith-based, teachers, sports coaches) on behaviour change. Though this review is not exhaustive, the relative low profile of fathers in enhancing knowledge and healthy choices in their sons and daughters is surprising and implies, as with maternal/U5 health interventions, that family health is seen as a mother's responsibility. The role of fathers in anti-violence campaigns is explored in the behaviour change section below, with acknowledgement that the health sector is not the main driver of these types of programmes.

[14] It should also be noted that rapid rises in HIV rates in Eastern Europe in the 2000s were caused by intravenous drug needle sharing. For parents and their children, this practice is probably even harder to discuss openly than sex. No studies in the literature review examined this form of risk.

Within the scope of increased numbers of CHW in LMIC[15] there is currently strong interest in also expanding the CHW role for maximum efficiency. The CHW concept incorporates a wide range of local, non-specialist health support from community volunteers or health workers. However, a common approach for maternal and child health is scheduled home visits, which is at the foundation of World Vision's Timed and Targeted Counselling (ttC) to implement the 7-11 strategy. With the focus consistently on mothers and under-fives, other members of the household receive little health benefit from the visits. A variety of projects have aimed to address this perceived inefficiency by introducing adolescent reproductive health (in particular for girls) into the CHW portfolio. A review of 106 articles on the topic (Koon et al. 2013) concluded that enthusiasm for the idea has led to CHW adolescent programmes scaling up too quickly, without full rigour on either purpose or results, including on the basic premise of reducing maternal and child mortality. At the same, it found that there was logic in filling some of the gaps in monitoring and advising adolescents at a very local level with CHWs who were interested in specialising in this area. Koon's review also noted – unsurprisingly – that paid CHWs are more effective in fulfilling core and additional duties than unpaid volunteers. A Pathfinder study of CHWs working with adolescent girls in Azerbaijan reiterated this observation. It found that upskilling CHWs to work on adolescent health risks was a lighter task than expected as many of the messages are simpler than those relating to nutrition and care of infants. With CHWs equipped with adolescent 'talking points', the project resulted in threefold increase in adolescent girls' knowledge of contraception and STIs including HIV. Parents were happy with the approach as CHWs were already trusted in their homes and community. However, appropriate compensation was considered essential for retaining CHWs with adolescent specialisation.

Household influences that may affect adolescent health rights include traditional leaders, chiefs or (in the case of some urban settlements, informal leaders), as well as leaders and dutybearers within faith-based organisations. Overwhelmingly male apart from a handful of faith denominations, these people dictate local culture and thus can contribute positively or negatively to social issues such as the uptake of immunisation, support and reduced stigma for unmarried mothers, mentally ill adolescents, boys and girls who are known to be HIV positive and other vulnerable health groups, and the elimination of harmful practices such as FGM[16] or male initiation rites. The African Youth Alliance called on traditional leaders including young kings from the traditional kingdoms of Uganda to drive public acceptance of condom use among teenagers (see highlights section below), while World Vision's own Channels of Hope has delivered strong results around greater family acceptance and understanding of the need for open discussion and education on STIs/HIV.

The 2007 WHO report "Helping parents in developing countries improve adolescent health" offered this excellent analysis of the importance of the parental role, and also some of the challenges to be overcome. It based findings on six different cross-national studies representing 53 different countries and regions of the world. The report also contains suggested indicators for measuring improvements to parental communication.

"Parents' roles can be organized into five dimensions, each of which has specific influences on adolescent health outcomes: 1. connection – love; 2. behaviour control – limit; 3. respect for individuality – respect; 4. modelling of appropriate behaviour – model; 5. provision and protection – provide.

Regardless of focus, (projects) tend to incorporate the concept of parent roles indirectly, but they lack knowledge of the relationship between particular parenting roles and adolescent outcomes. Almost all projects implicitly acknowledge the importance of provision and protection, most (26 of 34) address issues of connection, about one quarter (8 of 34) include skills for behaviour control, a few (3) specifically identify the influence of modelling of appropriate behaviour, and another 3 projects explicitly consider the fostering of respect for individuality in their activities. All projects regard parents as one component of a larger, multi-pronged set of interventions. This typically includes activities directed to adolescents themselves, and sometimes for school personnel, community leaders, health workers, and media organizations. All projects place a priority on engaging the local community in their parenting interventions. Some hold community meetings or focus groups, or work with village communities or local technical committees. Some incorporate a parenting curriculum into pre-existing groups, while others create their own groups and offer them in community spaces. Some projects mobilize community leaders as teachers or mentors."

[15] http://1millionhealthworkers.org/; In 2014 as part of EWEC's *Every Newborn* Action Plan, World Vision committed to supporting 100,000 CHWs in at least 40 countries by 2020.

[16] Note that FGM is of extreme concern to adolescent health in cultures where it takes place in early adolescence; however, other cultures perform the mutilation on girls in the first few months of their lives. A meta review of effective behaviour change to reduce FGM was included among the literature, but it is not specific to the practice in adolesence.

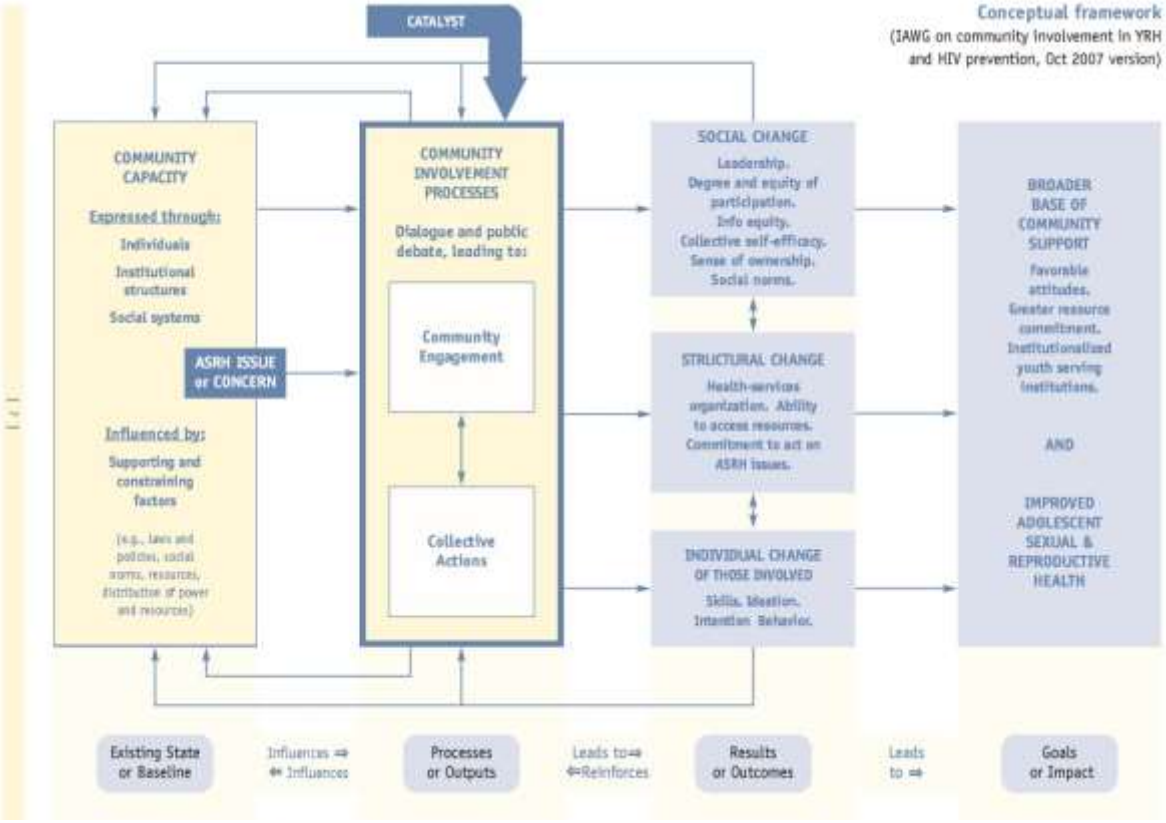
Highlights

- **Projects for parents**

The Child Development and Adolescent Health Centre (CDAHC) in New Delhi, India, created a school-based programme called Expressions: The Comprehensive Life Skills and School Mental Health Programme, which aims at improving communication between parents and adolescents in order to promote a healthier and more supportive relationship. For the parenting intervention, separate workshops are held for parents that help them to understand various types of communication patterns with their adolescents. Specifically, parents are provided with practical solutions and tips for improving communication with their adolescent children, such as how to manage adolescents' argumentativeness and defiance. By targeting parents' communication skills that focus on connection and respect for individuality, the programme has already shown positive results. For example, parents have stated that they are now better equipped to recognize mental health problems among their adolescent children and to manage effectively their adolescents' behavioural problems. (WHO 2007).

- **Shifting social norms for greater involvement with adolescents**

The Interagency Working Group on the Role of Community Involvement in ASRH presents a conceptual framework based on several previous studies, but in particular a model from Nepal that showed the importance of building acceptance and interest in the people around adolescents, rather than talking to young people in isolation. The Nepal initiative allowed mothers to dictate their aspirations for their daughters and revealed that they were similar to the goals of the project: keeping them at school, avoiding the need for early marriage, keeping them safe from gender-based violence. From these home-based principles the project built on existing networks to religious and local leaders, schoolteachers, health workers and other constants in a child's life until full support for culture change was evident. African Youth Alliance used the same framework across four African countries to engage and persuade key adolescent influencers; responsibility for sexual health was painted as a mark of personal respect, made 'cool' by the sanctioning of young local kings, backed up by the views of local religious leaders and, most importantly, of parents in a more open dialogue with their sons and daughters. Early marriage reduced, likelihood of condom usage increased and peer support networks for abstinence and choice strengthened. The IAWG sees these results as directly attributable to the change of culture surrounding the adolescents. A graphic of the conceptual framework is included below.



A note on fragile contexts and adolescent health

In fragile contexts, both boys and girls face significant setbacks in structures and services that help with prevention and treatment of adolescent health conditions: school is disrupted, rates of gender-based violence, assault and rape can be high, the social fabric and its natural 'safety net' of protection from older, respected community members is unreliable, clinics and medical services are temporary and often under-resourced, and young people are not likely to have either cash security or income generation prospects.

WRC (WRC 2014) suggests that rebuilding protective systems for girls in this situation benefits from an asset-based methodology, which is a widely used framework for positive adolescent programmes in HIC. Factors or 'assets' that will support and protect girls in healthy transition to adulthood are human, social, financial and physical. For girls in displacement this translates as: being in school, having strong friendship networks and social affiliation, access to a place to meet peers, access to relations of trust, information about health, and financial literacy. Building these assets early in life in theory brings increased self-protection and resilience, delaying first pregnancy and age of marriage due to other options, decreased gender-based violence (and its psychological impacts) and greater labour market participation. The Safe Space model, described over three different settings in the WRC report, builds and nurtures all of these assets. Its success depends on availability of emergency funding, quality teachers and appropriate referral networks between health education and health practitioners. Community-based components: mentorship, community mobilisation, livelihoods, are challenging to provide in a fractured social setting. In particular, formal articulation of community-based responsibility for protecting girls from violence is an important step that can be overlooked in a humanitarian setting, while livelihoods programming is unlikely to include adolescent girls. Another barrier acknowledged by WRC is that the Safe Spaces do not necessarily attract the most health-vulnerable: girls with a disability, girls heading a household or girls who are already married. Reaching these girls will be contextual, 'requires additional effort and thoughtful outreach strategy.' (WRC 2014: 11)

In terms of access to ASRH treatment and counselling in humanitarian settings, the literature offers several offers several replicable case studies. All examples below are from the WRC/Save the Children summary report on adolescent health in humanitarian settings (WRC 2012).

- In Thailand, local network Adolescent Reproductive Health Network operated a youth centre clinic combination in Mae Sot, a volatile border setting. Operating during daylight hours, but with an emergency night manager resident, it had capacity for onsite counselling and basic checkups with good referral networks to mainstream health services. As well as some medical personnel, the centre operated through peer educators aged over 18, who were seen by the younger visitors as reliable sources of information for their localised experiences. This was a safe and quiet space for girls of any age, offering discreet value adds for those who needed it (WRC 2014).
- In Colombia, a context of massive displacement and population mobility, Profamilia worked with government to introduce a new set of services with a youth focus (10 to 24) along the semi-rural Pacific coast. In total, Profamilia opened six clinics plus a mobile health brigade and on-call transport for access. The majority of staffing was through peer education but unlike many other projects, the educators received significant (120 hour) training in adolescent health, as well as helping with the design of the facilities. While no formal compensation was offered, the educators showed better retention rates than in other similar models (ICRW 2014: 23).
- ARC's programme in a long-term camp in Rwanda runs in and outside schools, with drama and other community-based messaging core to the programme. Part education, part service promotion, the dramas reach out-of-school adolescents while ARC assists with referrals to the Safe Space or to more formal health service such as family planning, premarital consultations and VCT. The programme also used adolescent health tools to expand the knowledge and role of local VCT counsellors, a cost-effective idea that also increased community comfort and acceptance of their role.

2. What community-level intervention mechanisms have been most successful in promoting healthy behaviour change (uptake of AH services, healthy lifestyles and ASRH) by adolescents (boys and girls)?

Behaviour change is inherent in all projects included in the review, including change by adolescents and by those around them. Thus, this is not really a separate research question; however, it does provide an opportunity to highlight tactics that are used to good effect in convincing adolescents to look after themselves in different, better ways. The four mechanisms described below should not be taken as isolated models, but as components that bring about behaviour change in and around adolescents.

Media and marketing

Though it can be expensive, social marketing and campaigning on adolescent health behaviour change has a large reach and is therefore cost effective. It is also an area that sees good levels of private sector investment, from condom manufacturers through to pharmaceutical CSR. AstraZeneca, a longterm investor in adolescent health including community-level project, provides an overview of campaigns for adolescents to address later life NCD (AstraZeneca 2014). The report argues that familiarity with the negative health implications of obesity, smoking, heavy drinking and other soft and hard drugs is much stronger in wealthy countries where public health campaigns are ongoing. Health advice is less consistent in LMIC and the poorer the country, the less likely it is that the government is spending money on interventionist marketing. Marketing that targeted young to mid adolescent boys with messages about reduced capacity as adults was often new information for the age group and was shown to work (in reducing smoking in India and alcohol consumption in Vanuatu (AstraZeneca 2014).

ICRW concludes that the best value for money comes with a multi-component campaign. Their study found that radio-only campaigns increased knowledge, but radio combined with print materials, posters, street theatre and general 'brand' was more likely to influence behaviour. They offer the case of Nicaragua's 'Somos Diferentes, Somos Iguales' (We are different but equal), a Puntos de Encuentro project that aimed to reduce gender stigma and sexual coercion under the objective of HIV prevention. A soap opera, radio, local appearances and take-home materials reiterated aligned messages, resulting in not only increased knowledge but also in transformation of social norms for the age group. Interpersonal communication and girls' participation improved and the reported use of condoms with casual partners increased significantly (ICRW 2014).

ICRW offers another private sector business case in the form of the social franchise. These are networks of providers who use common marketing and branding techniques to provide health services. By increasing specialisation in adolescent services, along with the benefits of lower cost promotion of these services that come with being part of a franchise, facilities have successfully increased the number of adolescents seeking healthcare (ICRW 2014). Connected to this idea (also see Section 3: Faith-based settings), in many countries a large proportion of health facilities are owned and operated by faith-based foundations. Institutional realignment to incorporate adolescent health themes, in particular, maternal care and substance use, brands these foundations in new ways and adds to their appeal and effectiveness as responders to the most vulnerable (see Uganda case study, HNP 2012).

Livelihoods opportunities

Several projects combined ASRH with livelihoods or microfinance for a full and practical life skills package (Straight Talk Foundation in WRC 2012, Ellsberg et al. 2015). The rationale is that low opportunity and limited aspiration drive negative health choices. How young people view their future has a strong correlation with their current health risk decisions (Weintraub 2015). Therefore, encouraging adolescents who are out of school or considering leaving to recognise their options in employment, health, community engagement and family planning helps to restore hope and the sense that they are in control of their lives.

In Kenya and Uganda, the Population Council worked with financial institutions to implement a program known as TRY (Tap and Reposition Youth) in which girls open a savings account, join a savings group that meets weekly and is led by a female mentor, and receive basic financial and health education. In Kenya, girls in the program were three times more likely than girls in a comparison group to save money on a weekly basis, and they were significantly more likely to know about at least one contraceptive method and understand that HIV can be

transmitted through sexual contact. In Uganda, compared to girls who did not participate in the program, girls who participated were 3.5 times more likely to name at least one correct method of HIV transmission, 3 times more likely to know at least one method of family planning and 1.5 times more likely to have had an HIV test. TRY participants were also deemed better able to negotiate sexual relationships, including three times more likely to insist on a condom and more confident to refuse sex (IYWG 2013).

Faith-based: 'believe that you can change'

Religion is an important structural and social element in almost all LMIC. Children growing up under the guidance of a particular faith are aware of what it means to live a 'good' life and will strive to do so. This often becomes more difficult during the transition through adolescence to adulthood, where both girls and boys can be exposed to negative role models, manipulation and coercion, that cause them to make mistakes. Literature suggests that when children take part in life skills projects, those who are already taking health risks (multiple sexual partners, substance use) are less likely to modify behaviour than those who are not (Mathews et al. 2015). A study of health behaviour intervention through the Anglican Church in urban Cape Town (Mash & Mash 2012) noted that a key factor in success was the belief that a person could change, and that it was not already too late to live a better life. The project appointed peer and adult role models as leaders of youth groups where discussion and role plays took place (rather than a more structured, 'didactic' curriculum). These discussions were not theologically based, but focused on 20 life skills, among them self respect, respect for one's body and physical fitness. Parents also took part in sessions to enhance intergenerational communication. The project was successful in delaying sexual debut in girls and boys and increasing condom usage in those who were already sexually active.

Gender-based violence programming

Though this literature review aimed to focus on health-related interventions, the importance of reducing gender-based violence, including community/state tolerance of gender-based violence, makes it imperative for inclusion as fully interdependent with adolescent health outcomes. Positive change in how boys value and treat girls is key to HIV reduction and treatment, sexual and reproductive health for girls and women, mental health, violence, injury and self harm. Ellsberg's study on violence in adolescence suggests that the ratio of prevention to treatment programmes for sexual violence is higher in LMIC than HIC, probably because there are limited resources for governments and CBOs to be working in psychological support and trauma reduction compared to a country like the US or UK (Ellsberg et al. 2015). The majority of LMIC prevention work is non-government. Some governments deliver life skills curriculum including violence reduction through schools, particularly in Latin America. However, school programmes are broad rather than targeted on gender inequity. ICRW suggests that the health focus on girls challenges effective behaviour change programming for boys and men. Successful pilots or short term projects show appropriate results but are rarely scaled up, and most of the work taking place on male puberty, masculinity and life choices lies within knowledge rather than influence.

Stepping Stones is a GBV model widely used as an add-on to HIV projects throughout Africa[17]. It incorporates gender equity, communication, relationship skills and HIV awareness, delivered as a series of participatory sessions or 'stepping stones' to better life skills. Designed for adults, it has been used with adolescents less frequently; however one example of Stepping Stones for this age group was included in the review, delivered by peer educators across multiple sites through the Ethiopian Kale Hiwot Church (USAID 2004). This was one of several initiatives under the EKHC adolescent health programme which together delivered strong results in increasing family planning and contraception use in adolescents and adults.

A case study from South Africa (Mathews et al. 2015) describes the participation of nearly 3500 school children in after school group sessions designed to stop the cycle of early and violent sexual debut. With an average age of 13.8, 82% of the children had already had sex at least once and 10% admitted to being a perpetrator of rape. 1 in 8 had tried to commit suicide in the last year. Participants described the sessions as fun and relevant, and results met targets in indicators such as reduced number of sexual partners, likelihood of using a condom or (for those who had not yet had sex) delaying sexual activity. Another goal the project achieved was to encourage uptake of the school nurse service. Examining this outcome in more detail, the study found that girls were more likely than boys to visit the nurse for discussions about SRH; the main topic for boys was how to cope with being

[17] http://www.steppingstonesfeedback.org

bullied. Indicators on reduced sexual violence and rape were not yet available.

3. What are success factors and barriers in promoting adolescent sexual and reproductive health behaviours within faith-based settings?

Four resources are highly recommended as an overview to the role of faith organisations in adolescent health: UNICEF's *Partnering with Religious Communities for Children*, the IAWG's *Religion and Development post-2015*, UNFPA's *Enhancing Sexual and Reproductive Health and Well-Being of Young People: Building Common Ground between the United Nations and Faith-Based Development Partners* and HNP's *The Role of Faith-Inspired Health Care Providers in Sub-Saharan Africa.* These documents recognise the great power and reach of religious organisations as moral guides and mentors, as imparters of knowledge, practice and culture, and as institutions with significant resources at their disposal. Faith-based organisations are one of the largest providers of health services directly, through foundations set up for the sick, the elderly and other vulnerable groups including pregnant girls and women. They conduct outreach to the homeless and to drug users, many of them in the adolescent age bracket. They are also increasingly prominent in quality interventions for reproductive health. In 2011, representatives of all major religions signed the Interfaith Declaration to Improve Family Health and Wellbeing, formalising their role and responsibility to contribute to public health including the healthy timing and spacing of pregnancy.

UNFPA notes that there are risks to generalising on the role of faith-based organisations which vary greatly in their size, wealth, capacity, governance and prevailing values (UNFPA 2013:2). The debate around appropriate family planning and contraception methods is highly contextual and largely cultural. The same religion or denomination of a religion can preach and believe different messages in different countries. For all, tightly held cultural values around family planning and child-rearing are based on the need for a continued social fabric that weaves one generation safely to the next. However, many religious leaders are now successfully arguing that these values should promote and not harm the advancement of human life, contentment with the world and joy with God.

Interventions by faith-based organisations comprised eight of the studies included in the review. It is worth noting that of the eight, only four are using theological doctrine. The other four are enabled by faith organisations through their core values but have little to do with specific religious teachings or reflection. They are:

- A partnership between the three largest religious medical providers in Uganda, the Uganda Protestant Medical Bureau (UPMB), the Uganda Catholic Medical Bureau (UCMB) and the Uganda Muslim Medical Bureau (UMMB), to provide improved coverage of adolescent-friendly family planning and expand youth-friendly clinics (HNP 2012)
- A partnership between Pathfinder and the Christian Health Association of Ghana (who provide 35% of total healthcare nationally) to enhance youth-friendly services and outreach to young mothers (married/unmarried) (Burket 2006)
- A successful 'Abstinence Plus' curriculum for young people and their parents in South Africa, taking place annually through Anglican church youth groups. The model emphasises delaying but also gives appropriate information, allowing adolescents some leeway in 'benefit of the doubt'. (UNFPA 2013)
- Also in South Africa, an urban programme through the Anglican church targeting 10,000 youth from lower socio-economic backgrounds using peer educators and a curriculum based on increasing self esteem (also see behaviour change section) (Mash & Mash 2012)
- In Islamic Nigeria, the local council of mosques Ulama used the Koran to generate a guide for Imams to use for ASRH including elements of self-respect, gender equity and family planning (Burket 2006)
- In Egypt, Pathfinder held formal training for clergy (Islamic and Christian) to improve their technical knowledge of the reasons for healthy timing and spacing of pregnancy. Participants were convinced by the argument and the science behind it and incorporated family planning discussions more effectively into their teaching and community interactions. (Burket 2006)
- An analysis of religious organisations' contributions highlighted significant support from all major LMIC context faiths (Buddhist, Hindu, Jain, Islam, Christian) in the last two decades to improving immunisation rates, especially for polio, and suggested that this could be replicated for hepatitis (IAWG 2014)
- A formal and integrated programme from the Ethiopian Kale Hiwot Church to offer HIV and family planning services to most vulnerable adolescents, including out of school youth, commercial sex workers, HIV positive prisoners and orphans/child-headed households. This programme also delivered the peer

educator Stepping Stones against gender-based violence (see p. xx) (USAID 2004)

Considering these cases, the most significant barrier appears to be continued stigma against condom use, though noting that some of the examples are a little old and may now experience fewer challenges in this regard due to the global reframing of adolescent health as a priority. The Pathfinder project stagnated for several months over the group's concern with distribution of condoms which Pathfinder believed to be 'non-negotiable.' A missing piece for the Nigerian Koran teachings was the use of condoms.

Another risk factor to comprehensive and supportive ASRH is the lack of engagement with local faith leaders at the planning stage. Some hesitation on teaching sex education or making contraception and family planning available to the unmarried will exist in almost any culture, but evidence shows that early, consultative preparation for adolescent education (peer, school or community) will influence stakeholders including faith-based to be more open towards traditionally restricted content.

To come as far as the 2011 Declaration, considering that the majority of faith decision makers are male, shows a significant shift of faith culture in response to the growing awareness of preventable illness and deaths, wasted productivity and intergenerational poverty occurring as a result of exclusion of women. However, it is not given that this will translate into action and compassion at local level without local community and congregation will. Faith organisations at all levels are power structures, with appropriate protocol, clear documented values and purpose and at times ponderous process in bringing about institutional change. Literature, and the evidence from it, recommends that introduction of new ideas concerning the raising of children should be community-built, starting with local representatives of the faith with the courage to identify with thoughts and needs of adolescents of both genders. World Vision's Channels of Hope model began in much the same way before evidence of its value led to more formal implementation partnerships with Christian and other faith bodies.

From an international perspective, UNFPA suggests the role of international faith-based organisations is similar to that of any partner network: building capacity of aligned organisations to deliver improvements to the vulnerable living amongst them, and mapping and reporting progress across regions to assist with international policy and direction. They may also act as donor partners, as in many of the Pathfinder examples, but core planning and negotiation should be taking place between national or local entities.

It is worth pointing out some limitations in this section. Firstly, only ASRH and HIV are discussed above. With regard to the WHO framework for adolescent health, undoubtedly faith-based organisations are achieving results daily in terms of mental health, violence reduction and physical activity. They are the traditional provider of youth activities and understand well the importance of leading busy, active lives in teenage years. Reviews of the value of these daily contributions were obscure compared to the core purpose of this paper so were not pursued. Secondly, the lack of resources from Buddhist or Hindu settings, or in fact from Christian or Islamic contexts outside Africa, is noted. All major faiths are significant health and public health providers in their own contexts. A more comprehensive review could allow for more broadly relevant findings.

Conclusions: gaps and the role of the health sector

The WHO framework offers a lens for thinking beyond sex education and life skills to incorporate the reduction of risk later in life and positive healthy habits and choices that will remain important into adulthood. Effective adolescent health interventions will address more than one form of health risk, incorporating elements of youth-friendly provider services, community-based healthcare access and prevention programmes, peer influence and enhanced family-based knowledge and interest. This calls for complex programming across multiple sectors, drawing in a variety of institutional and community-based roles. The WHO framework helps to articulate the changes needed to save lives, but not necessarily the interdependencies of programming required to achieve this change. In many of the framework outcomes, for instance increasing physical activity or reducing violence and injury, health sector specialists need only play a strategizing role. It becomes important to apply models from other sectors in partnership rather than 'reinventing the wheel' on associated models for reduction of gender-based violence, life skills and leadership, disaster risk reduction and peacebuilding. Based on commonality of the two main objectives in the review, ASRH and reduction of violence and injury, the diagrams below illustrate component programming with health sector responsibilities in blue and other sectors in orange. The third diagram indicates adolescent health behaviour and support interventions as a subset of the full strategy required to reach World Vision's broader objective of 'child wellbeing'.

The diagrams show that no adolescent health programme will fall solely into the remit of the traditional health sector. So, what gaps are shown in the literature that continue to require specific health expertise?

Firstly, support and services for unmarried adolescent pregnancy, whether carrying to term or seeking alternatives, is taken for granted in most HIC but extremely limited in LMIC. Even for agencies and cultures that

do not condone abortion, the imperative to provide post-abortion care is increasingly obvious. Girls and women who terminate without medical assistance represent 13% of all maternal deaths, usually not during the procedure but due to post-abortion complications[18]. Adolescents are more likely than older women to take an abortion decision later in the pregnancy, significantly increasing risk. Natural miscarriage after the first trimester also represents risk unless medically attended. Facilities for nursing and supporting girls in this situation, as well as better knowledge of where these facilities are and how to reach them in an emergency, are lacking. For girls who remain pregnant, services are not adolescent-friendly and medical staff may apply personal prejudice to the detriment of quality care. This represents risk not only to the mother but also to her newborn. Provider and community-based solutions are required to ensure full inclusion of unmarried mothers in maternal healthcare systems.

Secondly, adolescent health for boys requires specific interventions including advisory and medical. This extends beyond the basics of STIs and life skills. Good results have been achieved through adult-child mentorship including in faith-based communities, as well as peer education with older boys and youth. Peer pressure on boys to take risks in sexual behaviour, substance and tobacco use, particularly in low income or disadvantaged settings, can be reduced through timely interventions from trusted advisors explaining the health implications of poor decisions. At the same time, the literature shows that boys are less likely to consult doctors about their sexual health, that doctors can take advantage of their naivety when they do, and that the traditional focus of CHWs is on female reproductive health. Prevention, referral and treatment are all problematic areas contributing to ongoing challenges for boys in their health-seeking behaviour.

Thirdly, poor menstrual hygiene contributes to school absenteeism, reproductive tract infection and challenges to self esteem for girls, regardless of sexual activity. This issue is even unspoken among NGOs who often cite 'lack of a separate toilet' as a reason for girls dropping out of school without specifics on how often this is due to needing to manage periods. Where low gender empowerment exists (for instance, India, Nigeria, Pakistan) mothers teach girls frugal but unsafe methods of containing menstruation, often using the same cloth over a lifetime (WaterAID 2010). Tools for educating girls, their mothers and their fathers (who control the family budget) on the importance of safe menstruation are urgently needed in these and similar contexts.

Fourthly, HPV immunisation offers opportunities for integrated health checkups in girls and boys. While this is largely dependent on government policy and supply of the vaccine, health camps have been an attractive model in the past offering free, fun, voluntary health checkups for adolescents who might otherwise avoid the doctor. The importance of this vaccine in eliminating over 99% of cervical cancer cases cannot be underestimated. Technical specialists have a role to play in policy influence to ensure the vaccine is available as well as designing innovative rollout (schools or community) that incorporates a broader scope of adolescent health services.

Fifthly, girls who have taken up early marriage are a forgotten entity within the adolescent health framework. They are removed from school and 'fun' learning for adolescents, and in some contexts become fully dependent on the advice of their husbands and in-law families. The literature recognises adolescent brides as among the most health-vulnerable of mothers in terms of early pregnancy, nutritional deficiency in mother and child and access to appropriate MNCH and family planning services.

Lastly, both the service provision arm and the local community/worship function of faithbased institutions require technical support. The first is highly equipped and knowledgeable but requires advocacy towards introducing adolescent friendly services. The second is increasingly willing to raise controversial issues but often lacks the scientific expertise to influence and convince. The messages for HIV prevention and treatment in the past have been simpler than those pertaining to the multiple nuances of family planning and sexual/reproductive health. Support is required to ensure community-based messages are consistent and fully owned.

[18] http://www.who.int/reproductivehealth/topics/unsafe_abortion/magnitude/en/

Annex 1: Bibliography – case study references

Citation	Description	Sector	Type	Prevent / treat?	Target	Country	Region	Ref.
African Youth Alliance (2004), "*Integrating Adolescent Sexual and Reproductive Health Programming into Vocational Education and Training in Zanzibar: AYA's Advocacy for Policy Formation and Support for Pilot Implementation*" PATH Tanzania 2004	A five year, five country campaign to educate youth (10-24) on SRH. Five partners implement AYA's behaviour change communication strategies of life planning skills (LPS) training, edutainment (educating through entertainment), peer education, community mobilisation, and adult-child communication. Also successful advocacy to incorporate LPS into govt. curriculum, cadet school and workplaces.	*ASRH HIV*	*Community-based*	*Prevention*	*Both genders*	*Multiple (Tanzania highlighted)*	*Sub-Saharan Africa*	*pp.18, 20, 21*
AstraZeneca 2014, *Non-communicable diseases and adolescents: an opportunity for action,* AstraZeneca working paper	Makes a good argument for adolescent intervention on adult disease by changing marketing laws on tobacco, poor food choice, alcohol. India anti-tobacco and Vanuatu anti-alcohol campaigns were effective.	*Substance use Tobacco control*	*Provider led*	*Prevention*	*Both*	*Vanuatu*	*Pacific*	*p.23*
AstraZeneca 2014(2), *Young Health Programme Zambia 3 year report*	Peer educators (drama/school), Youth Friendly Corners with pool tables and comfy furniture. Charging for pool table use covers cost of street drama. Promote, but don't offer SRH services.	*ASRH*	*Peer led*	*Both*	*Both*	*Zambia*	*Sub-Saharan Africa*	*p.18*
AstraZeneca 2013, *Young Health Programme Brazil 3 year report*	Peer educators recruit young people to attend life skills sessions. Highly inclusive and participatory. Activities carried out were age-sector; for young people between 10 to 14 years old, the topics included gender, maternity and paternity whilst topics for older adolescents between 15 to 19 years focused on SRH, HIV prevention, early pregnancy and use of alcohol and other harmful substances. Also repositioned CHWs successfully.	*ASRH*	*Peer led*	*Prevention*	*Both*	*Brazil*	*Latin/South America*	
AstraZeneca (2013(2)), *Young Health Programme India 3 year report*	Focused on training/retraining with stronger holistic health messages: peer educators, teachers, medical staff. Included malaria, dengue, diarrhoea (and WASH components) along with reproductive health.	*ASRH Substance use Integrated mgt*	*Community based*	*Both*	*Both*	*India*	*South Asia*	
Barry et al. (2013), "A systematic review of the effectiveness of mental health promotion interventions for young people in low and middle income countries", *BMC Public Health* 2013, 13:835	Considered 22 life skills/gender equity projects incorporating 6-18yo age group, all school based. After school programmes for children affected by conflict generally strong results - these programmes also tended to be longer term up to a year. Nepal project included specific depression prevention and reported strong results, though different between genders: anti-aggression in boys, pro-social in girls.	*Mental health Violence and injury Substance use*	*Peer led*	*Prevention*	*Both*	*Nepal*	*South Asia*	*p.17*
Basterfield et al. (2014), "Relationship Between Constructions of Masculinity, Health Risk Behaviors and Mental Health Among Adolescent High School Boys in Durban, South Africa", INTERNATIONAL JOURNAL OF MEN'S HEALTH, VOL. 13, NO. 2, SUMMER 2014, 101-120	In simple terms: adolescents who like school, 'school connectedness', are healthier and take fewer risks. Making school inclusive and likeable particularly once boys start to identify with negative aspects of masculinity is a challenge outside the health programming realm.	*Violence and injury Substance use Physical activity*	*Community led*	*Prevention*	*Boys*	*South Africa*	*Sub-Saharan Africa*	*p.16*
Bellows N., Bellows B. and Warren C. (2011), "The use of vouchers for reproductive health services in developing countries: systematic review", *Tropical Medicine and International Health*, volume 16 no 1 pp 84–96 January 2011	In Nicaragua, use of contraceptives doubled among sexually active nonpregnant voucher redeemers and voucher receivers had significantly higher utilization rates of reproductive health care and condoms compared to non-voucher receivers. Some aspects of service quality improved over time.	*ASRH*	*Provider*	*Prevention*	*Both*	*Nicaragua*	*Latin/South America*	
Bradley (2011), Evaluation of Stepping Stones as a tool for changing knowledge, attitudes and behaviours associated with gender, relationships and HIV risk in Karnataka, India, BMC Public Health 2011, 11:496	(not a youth focus). SS could be enhanced by efforts to better engage existing community opinion leaders, to empower and train participants as community change agents, and to support the development of village-level action plans that combat sexual stereotyping and risky behaviours that lead to unhealthy sexual relationships.	*Violence and injury*	*Community based*	*Prevention*	*Both*	*India*	*South Asia*	
Burket, M. (2006), Advancing reproductive health and family planning through religious leaders and faith-based organisations, Pathfinder International 2006	CHAG Ghana is a church-based foundation providing around 35% of total healthcare. Pathfinder partnered to introduce adolescent services to CHAG facilities including condom distribution (a challenge) and youth-friendly corners.	*ASRH*	*Provider led*	*Treatment*	*Both*	*Ghana*	*North/West Africa*	*p.23, 25*
Ibid.	The Ulama conducted an exhaustive search of Islamic writings, including the Koran, to develop Reproductive Health Issues in Nigeria: The Islamic Perspectives. This handbook outlines modern family planning and reproductive health practices (such as child spacing by using contraceptive pills or condoms, postabortion care, and harmful traditional practices), and gives the Islamic view on each of the modern teachings.	*ASRH*	*Home, family, culture*	*Prevention*	*Both*	*Nigeria*	*North/West Africa*	*p.25*

Care (2007), Care Georgia Guria Adolescent Health Project Final Evaluation	Used change agents (peer), education/social marketing, theatre/forum, microgrants for local ASRH initiatives led by current or former peer educators. Great results. Evaluation respondents thought theatre forum should be scaled.	*Violence and injury ASRH*	*Community-based*	*Both*	*Both*	*Georgia*	*MEER*	
Ellsberg, M. et al (2015), Violence against women and girls 1: Prevention of violence against women and girls: what does the evidence say? The Lancet 2015; 385: 1555–66	IMAGE model tested whether adding gender and HIV components to microfinance for women could contribute to reductions in intimate partner violence. Included ten participatory training and skills-building sessions on HIV, cultural beliefs, communication, and violence. After 2 years, a cluster-randomised trial showed a 55% reduction in reports of physical or sexual partner violence from women. Model now scaling up in South Africa and expanding to Tanzania/Peru.	*Violence and injury HIV*	*Community based*	*Prevention*	*Both*	*South Africa*	*Sub-Saharan Africa*	*p. 23, 24*
Evidence to Action (2015), *Assessing the effects of mCenas SMS education on knowledge, attitudes and self-efficacy related to contraception among youth in Mozambique*	Specific to contraception info. Two way, so recipients could ask questions. Included storytelling via longer SMS.	*ASRH*	*Provider led*	*Prevention*	*Both*	*Mozambique*	*Sub-Saharan Africa*	*p.14*
Fazel M., Patel V., Thomas S., Tol W. (2014), "Mental health interventions in schools in low-income and middle-income countries", *Lancet Psychiatry* 2014; 1: 388–98	Classroom based intervention (CBI) described as a model, widely used. Brief screening, followed by intensive group sessions of play/work/drawing, then a further screening to identify who might need further referral. Overall positive results but some mixed.	*Mental health*	*Community based*	*Both*	*Both*	*Sri Lanka*	*South Asia*	*p.16*
Ibid	SHAPE: a 'whole of health' approach in schools which also addressed violence and bullying, intensive training of school counsellors to recognise psychosocial symptoms	*Mental health Violence and injury*	*Community based*	*Both*	*Both*	*India*	*South Asia*	
Givaudan and Pick (2003), *A preventive programme for substance abuse in Mexico: Best practices*, The Mentor Foundation (draft)	Simple programme using a framework of life skills enhancement with no health technical specialisation. A 'self respect' curriculum and books books "Think before you act!" for teenagers and "let your adolescent fly" for parents. Used these for out of school adolescents as well.	*Substance use*	*Community based*	*Prevention*	*Both*	*Mexico*	*Latin/South America*	
Gottschalk L. & Ortayli N. (2014), Interventions to improve adolescents' contraceptive behaviours in LMIS; a review of the evidence base, Contraception 90: 211-225	Meta analysis. Important elements: affordability, fostering connectedness with an adult (parent, teacher, young mother) including parallel sex ed classes for mother and daughter. Media/multimedia also effective. Children can absorb it in their own time. Most programs use combination of elements so it is hard to say which one, or which combo, works best. Longer term projects work better than shorter term. Questions around reaching most at risk, due to school-based and to 'self-subscribers' who were looking for the information and thus more likely to use it.	*ASRH*	*Community based*	*Both*	*Both*	*Unspec.*		
Grainger et al. (2014) "Lessons from sexual and reproductive health voucher program design and function: a comprehensive review", *International Journal for Equity in Health* 2014, 13:33	:Voucher for STI, MNCH, SRH (not adolescent only). Available at pharmacies, also doorknocked to vulnerable households. Developed over time, now includes transport and nutrition, NFP but govt. scaling now. Nicaragua: adolescent emphasis at request of target population. Study cites further research that doctors also benefit from the adolescent voucher which highlights the particular needs of this age group.	*ASRH*	*Provider led*	*Prevention*	*Girls*	*Uganda*	*Sub-Saharan Africa*	*p.14*
HNP 2012, THE ROLE OF FAITH-INSPIRED HEALTH CARE PROVIDERS IN SUB-SAHARAN AFRICA AND PUBLIC-PRIVATE PARTNERSHIPS, Strengthening the Evidence for Faith-inspired Health Engagement in Africa, Volume 1, Jill Olivier and Quentin Wodon (eds.), HNP/World Bank	Example selected is church-funded but not a faith-based approach as such. 4 FB medical bureaus partnered with Pathfinder on improving facilities and skills to service adolescents. All project sites reported an increase in outreach services, and equipment and infrastructure devt. contributed to staff morale and interest. Improved ANC; referrals were taking place for the first time. Youth corners (and sports clubs!) in existing facilities.	*ASRH HIV*	*Provider led*	*Treatment*	*Both*	*Uganda*	*Sub-Saharan Africa*	*p. 23, 25*
IAWG (2007), *Community Pathways to Improved Adolescent Sexual and Reproductive Health: A Conceptual Framework and Suggested Outcome Indicators.* December 2007. Washington, DC and New York, NY: Inter-Agency Working Group (IAWG) on the Role of Community Involvement in ASRH.	Suggests a conceptual framework based on previous studies, in particular 2004 Nepal study that showed community-built ASRH (see Mathur 2004). African Youth Alliance also used the framework to engage different levels of persuasion: responsibility as 'cool', sanctioned by traditional 'kingdom' leaders, sensitisation of religious leaders: directly attributable results on early marriage, more networks and more enthusiasm for them.	*ASRH*	*Community based*	*Both*	*Both*	*Nepal*	*South Asia*	*p.21*
ICAI (2012), Girl Hub: A DFID and Nike Foundation initiative, independent review to DFID 2012	Girl Hub 12+ works with girls 10-12 (classes, magazines) to prepare them and increase their confidence on what is to come. Rwandan President has increased his own commitment to adolescent girls' wellbeing using the concept.	*ASRH Nutrition*	*Peer led*	*Prevention*	*Girls*	*Rwanda*	*Sub-Saharan Africa*	
ICRW (2014), *Understanding the Adolescent Family Planning evidence base*, International Centre for	India's PRACHAR project, talks to girls about longterm planning. Successful in reducing early marriage, keeping girls at school.	*ASRH*	*Community*	*Prevention*	*Girls*	*India*	*South Asia*	

Research on Women/Gates Foundation July 2014			based					
Ibid	Community-based girls' clubs with cascading leadership structure and continuous training and mentoring for sustainability. Workshops are conducted with girls and their mothers on topics such as self-esteem, life skills, developing aspirations and planning for the future, sexual and reproductive health and HIV/AIDS prevention.	*ASRH*	*Home, family culture*	*Prevention*	*Girls*	*Guatemala*	*Latin/South America*	*p.16*
Ibid	General conclusion that large-scale campaigns are most effective when coordinated with other interventions. Including culture change to reduce social pressure for early marriage/early pregnancy. Multiple channels with mutually reinforcing messages.	*ASRH*	*(holistic / several)*	*Girls*	*Prevention*	*Unspec.*		
Ibid	Info on cash transfers in Ethiopia, Malawi. World Bank in Malawi tested conditional against unconditional and found different, but positive, outcomes from both. Notes conditional cash transfer when the condition is staying at school isolates vulnerable out-of-school girls.	*ASRH*	*Provider led*	*Prevention*	*Girls*	*Malawi*	*Sub-Saharan Africa*	*p.14*
Ibid	Info on school-based programmes. Widely used, including peer mentorship, adult mentorship, curriculum or club-based. Review found school-based programs led by adults appear to be more successful than peer-led programs, particularly in regard to impacting sexual behavior.	*ASRH*	*Holistic / several*	*Prevention*	*Both*	*Unspec.*		
Ibid	Info on peer educator/"agents of change". Require assistance of teachers or expert trainers, and often work within existing structures, such as schools or youth centers, or may also conduct community-based outreach. Peer-to-peer education programs most frequently measured short-term outcomes and were found to be effective in changing adolescents' knowledge and attitudes. There is less evidence to suggest that peer approaches improve behaviors. The peer educators benefit more than their targets.	*ASRH*	*Peer led*	*Prevention*	*Both*	*Unspec.*		*p.18*
Ibid.	Info on parental involvement: Increasing communication between girls and mothers (in particular) highly effective but mothers must know more too. Report concludes: working with adolescents' family members, teachers, religious leaders and key gatekeepers is critical to creating an enabling environment that fosters acceptance of adolescent decision-making around avoiding, delaying, spacing and limiting births, as well as acceptance of adolescent use of family planning services.	*ASRH*	*Home, family, culture*	*Prevention*	*Girls*	*Unspec.*		.
Ibid.	Somos Diferentes, Somos Iguales used education-entertainment, including a social soap opera, radio programming, local capacity building, context-specific materials, and community outreach to reduce stigmatizing and gender inequitable attitudes, increase knowledge and use of HIV-related services, increase interpersonal communication about HIV prevention and sexual behavior, and strengthen youth leadership, among other outcomes. Report concludes from this and other cases that multichannel will increase behaviour change probability.	*ASRH*	*Provider led*	*Prevention*	*Both*	*Nicaragua*	*Latin/South America*	*p.18*
Ibid.	Somos Diferentes, Somos Iguales used education-entertainment, including a social soap opera, radio programming, local capacity building, context-specific materials, and community outreach to reduce stigmatizing and gender inequitable attitudes, increase knowledge and use of HIV-related services, increase interpersonal communication about HIV prevention and sexual behavior, and strengthen youth leadership, among other outcomes. Report concludes from this and other cases that multichannel will increase behaviour change probability.	*ASRH*	*Provider led*	*Prevention*	*Both*	*Nicaragua*	*Latin/South America*	*p.18*
Ibid.	Community based distribution. A study in Tanzania, Zimbabwe and Thailand found that 16 to 32 year olds used mobile clinics to access to HIV testing and counseling three to 10 times more often than brick-and-mortar facilities; this may be a promising strategy for wider reproductive health service delivery.	*ASRH HIV*	*Community-based*	*Treatment*	*Both*	*Thailand*	*East Asia*	*p.15*
Ibid.	Sports and recreation: Interventions that promote new skills and opportunities to use them, coupled with opportunities for reflection and dialogue regarding social norms, result in sustained reduction of harmful health behaviour. Sports are crucial.	*Violence and injury Physical activity Nutrition*	*Community-based*	*Prevention*	*Both*	*Unspec.*		
Ibid.	Youth centres with clinics: found to have only limited success in improving access to care or contraceptive use; they may be better positioned to improve reproductive health knowledge. In many places these centers have been found to be primarily used by young men for recreation. Considering low results, rarely appear cost-effective.	*ASRH Integrated mgt*	*Provider led*	*Both*	*Both*	*Unspec.*		
Ibid.	Social franchises are networks of providers who use common marketing and branding techniques to provide health services. When a Kenyan social franchise was specifically branded as providing services for adolescents and providers received training in youth-friendly service delivery, it was able to increase the number of adolescents seeking services.	*ASRH Integrated mgt.*	*Provider led*	*Both*	*Both*	*Kenya*	*Sub-Saharan Africa*	*p.23*

Interagency Youth Working Group *The Intersection of Economic Empowerment and Youth Sexual and Reproductive Health*, YouthLens No. 37.	The Population Council's TRY program began in 1998 as a group-based microlending scheme. After experiencing high dropout rates and low loan repayment, however, the program shifted its focus to a groupbased savings model called "Young Savers Clubs" in 2004. Under this model, youth in voluntary, self-managed groups meet regularly to contribute to their own savings and receive social support and entrepreneurship education.	*ASRH HIV*	*Peer led*	*Both*	*Both*	*Kenya*	*Sub-Saharan Africa*	*p.23*
Kesterton and Cabral de Mello (2010) "Generating demand and community support for sexual and reproductive health services for young people: A review of the Literature and Programs", *Reproductive Health* 2010, 7:25	Meta review. Highlights evidence on community engagement and the linking of school education programmes with youth friendly services, life skills approaches and social marketing and franchising. Key community gatekeepers such as parents and religious leaders are vital to generating wider community support. In general a combined multi-component approach seems most promising with several success stories to build on.	*ASRH HIV*	*Holistic / several*	*Both*	*Both*	*Unspec.*		
Koon et al. (2013), "A review of generalist and specialist community health workers for delivering adolescent health services in sub-Saharan Africa", *Human Resources for Health* 2013, 11:54	Reviewed 106 articles on the role of CHW in adolescent health services. Found scale up without rigour of purpose and gaps in quality, adolescent friendly community support that could be filled with strengthened knowledge and incentive for CHWs. Some questions around effectiveness of CHW in basic premise - reducing maternal and child mortality. Generalists vs. specialists - eg. specialist nutrition, specialist malaria. Has not yet been tried with appropriate scale as CHWs work mainly with heads of household.	*Integrated mgt of common conditions ASRH*	*Community-based*	*Both*	*Both*	*Unspec.*	*Sub-Saharan Africa*	*p.20*
Macphail et al (2013), Using HPV vaccination for promotion of an adolescent package of care: opportunity and perspectives, BMC Public Health 2013, 13:493	A study of adolescent women using academic health centres and private practices in the US for HPV vaccination noted that almost half used their vaccine visit to receive other medical or preventive services . The World Health Organization (WHO) has recommended leveraging this potential symbiosis by suggesting that the required HPV vaccination schedule be used as a platform from which to deliver screening programmes, provision of information, services, commodity delivery or other vaccines, particularly in LMIC. However, increases the cost of programme vs. introducing HPV in isolation. Also need to find a way to include boys as they don't usually take the vaccination.	*Immunisation*	*Community based*	*Prevention*	*Girls*	*Unspec.*		
Marie Stopes 2012, Delivering sexual and reproductive health services to young people: lessons from Marie Stopes International programmes, USAID/Marie Stopes International	Introduced mobile clinics specialising in SRH for garment workers. Not all factories wanted this and the model lacked backup in emergency visits or household discussions. Introduced a peer education scheme to help with support between clinic visits.	*ASRH*	*Community based*	*Both*	*Girls*	*Bangladesh*	*South Asia*	*p.17*
Ibid.	In South Africa, eHealth automated hotline for a variety of problems. Callback or tollfree number to talk to the right person. Also a website in Pakistan that works similarly but has email requests for information. Model 1 is more suited to low literacy contexts.	*ASRH*	*Community based*	*Both*	*Girls*	*Pakistan*	*MEER*	*p. 15*
Mathur S, Mehta M, Malhotra A. (2004), "Youth Reproductive Health in Nepal: Is Participation the Answer?" New York: EngenderHealth and International Center for Research on Women, 2004.	Action planning chose and designed 8 different intervention paths. Greater efforts to be holistic and draw in secondary dependencies such as livelihoods and social norms. Acceptable (but not outstanding) results with girls benefiting in particular. Note that even though adults had contributed and agreed to project design, they were not always receptive to the increased capacity and participation of children in society.	*ASRH*	*Community based*	*Both*	*Both*	*Nepal*	*South Asia*	*No*
Mash R., & Mash R. (2012, "A quasi-experimental evaluation of an HIV prevention programme by peer education in the Anglican Church of the Western Cape, South Africa", BMJ Open. 2012; 2(2): e000638.	Peer education programme focused on increasing self-confidence and the belief that anyone can change. 20 life skills for youth, 3 for parents (not health based, more to do with respect and communication. Most had been exposed to sex ed at school, and just under a third to other peer education programmes. Note: did not succeed in reducing sexual activity in those who had already begun, but did improve condom usage and delayed sexual debut.	*ASRH HIV*	*Community based*	*Prevention*	*Both*	*South Africa*	*Sub-Saharan Africa*	*p.24, 25*
Mathews et al. 2015 'Reaching the hard to reach: longitudinal investigation of adolescents' attendance at an after-school sexual and reproductive health programme in Western Cape, South Africa' BMC Public Health (2015) 15:608	6244 students invited to take part, 3451 got to the point of signed parental permission and baseline info. Incentives to attend included a loyalty card with cash bonus. Av. Age 13.8. 55% under 15 and 82% had had sex at least once. 31% had been victims of sexual violence, 10% had been perpetrators. 1 in 8 had tried to commit suicide in the last year. Goal was not only to change behaviour but also to get more students visiting the school nurse.	*ASRH HIV*	*Community based*	*Both*	*Both*	*South Africa*	*Sub-Saharan Africa*	*p.24*
McCleary-Sills et al. (2011), Vijana Tunaweza Newala: Findings from a Participatory Research and Action Project in Tanzania, ICRW	The Vitu Newala project ("Newala Youth Can") in Tanzania engaged youth in the participatory research process to understand and address the risks faced by adolescent girls in Newala. Girls ages 18 to 24 were trained to be researchers and to conduct sessions with younger girls (ages 12 to 17) to discuss their aspirations and roadblocks to achieving them. Through its participatory approach, Vitu Newala was able to improve adolescents' knowledge and self-efficacy for discussing sex and family planning with parents and other adults, with friends, and with (potential) partners.	*ASRH HIV*	*Peer led*	*Both*	*Both*	*Tanzania*	*Sub-Saharan Africa*	*p.18*
Pathfinders International, Improving Reproductive Health through Community-Based Services: 25 Years of Pathfinder International Experience	Azerbaijan CHW recruitment and training on specific issues, led to 3 fold increase in adolescent girls' knowledge of contraception and STI inc. HIV. Lesson: appropriate compensation will enhance results and longevity of involvement, CHWs need to be equipped with adolescent-appropriate 'talking points'.	*ASRH HIV*	*Family, home, culture*	*Prevention*	*Both*	*Azerbaijan*	*MEER*	*p.20*

Ibid.	Ghana program integrated nontraditional condom distributors in a trade—such as sewing or hair dressing—or selling goods or services in a location that attracts young people. The condom distributors provided RH/FP information and condoms to their clients. Though the project supported more peer educators (297) than nontraditional distributors (200), at the end of the five-year project, 58 percent of the more than 1,300,000 condoms distributed were through non traditional condom distributors.	*ASRH HIV*	*Community-based*	*Prevention*	*Both*	*Ghana*	*West/North Africa*	*p.19*
Perera, S. 2015, Case study on adolescent inclusion in Care Groups, Nigeria, International Medical Corps/TOPS/USAID 2015	Care Group Program with 60 Care Group Lead Mothers supporting 900 mothers in 5 health facility catchment areas. Adolescent girls were included in Care Groups as a pilot with the specific aim to promote optimal birth and health outcomes. Information is exactly the same, the point of difference is in convincing them/their husbands of the value of coming. A separate peer group overcomes their shyness in speaking in front of other women. Very successful.	*Nutrition*	*Home, family, culture*	*Both*	*Girls*	*Nigeria*	*West/North Africa*	*p.19*
Remesa et al. (2010), "Dusty discos and dangerous desires: community perceptions of adolescent sexual and reproductive health risks and vulnerability and the potential role of parents in rural Mwanza, Tanzania", in Culture, Health & Sexuality Vol. 12, No. 3, April 2010, 279–292	'Good Things for Young People, MkV' included extensive sensitisation with parents on the need for better information/communication. Parents acknowledged the need to do something, to strengthen their skills and knowledge about SRH and improve communication. Mothers also found it awkward to discuss menstruation with their daughters; some said they do not know when their daughters started menstruating. "Young women's information about periods comes from peers and money for sanitary pads from boyfriends."	*ASRH HIV*	*Communiy-based*	*Both*	*Parents*	*Tanzania*	*Sub-Saharan Africa*	*p.19*
UNFPA (2013), *Enhancing Sexual and Reproductive Health and Well-Being of Young People: Building Common Ground between the United Nations and Faith-Based Development Partners*	South Africa 'abstinence plus' curriculum for young people and their parents through youth groups.	*ASRH*	*Home, family, culture*	*Both*	*Both*	*South Africa*	*Sub-Saharan Africa*	*p. 25*
UNFPA (2013(2)), *Summary report of UNFPA-UNICEF joint programme on FGM/C: accelerating change*	Looks at results in 15 countries (Kenya most relevant to adolescent survival). A social norms perspective was at the core of the programme framework of the Joint Programme. Educational activities and community dialogues created a non-threatening space where people could reevaluate their own beliefs and values regarding FGM/C. A total of 20,941 religious and traditional leaders made public declarations delinking FGM/C from religion since 2008, and 12,753 communities committed to abandon FGM/C representing about 10 million people.	*Violence and injury*	*Home, family, culture*	*Prevention*	*Girls*	*Kenya*	*Sub-Saharan Africa*	*No*
USAID (2004), Assessment of youth reproductive programmes in Ethiopia, USAID/FHI360, April 2004	Review of current programming in ASRH Ethiopia. Youth want more recreational/sports facilities and libraries/reading corners. Such facilities could help to keep young people active, provide them with alternatives to sexual activity, and give them a place where they can gather to talk, vent, brainstorm, learn, and share with each other their experiences. Reducing provider bias against youth would help to improve access to services.	*ASRH HIV Physical Activity*	*Holistic /several*	*Both*	*Both*	*Ethiopia*	*West/North Africa*	*p.18*
USAID (2009), Final report of the Healthy Women in Georgia project 2003 – 2009, USAID/JSI Research and Training Institute	Close partnership with public policy to ensure services were strengthened for all female age groups. Extremely successful project. Translation into local language of all appropriate medical terms, so that health practitioners, teachers and youth attending sessions all used similar terminology.	*ASRH Substance abuse*	*Provider led*	*Both*	*Girls*	*Georgia*	*MEER*	*p.17*
USAID (2012), IFPS Technical Assistance Project (ITAP): Promoting Adolescent Reproductive Health in Uttarakhand and Uttar Pradesh, India. Gurgaon, Haryana: Futures Group, ITAP.	Remarkable awareness achievements. Grouped into two - early and late adolescence, also acknowledged married adolescents. BCC included significant adult and govt sensitisation and advocacy inc. state level workshops. Adolescent friendly centres, peer support, 'risky behaviour' scope. CHWs refer problems to AFCs instead of needing the specialist ASRH counselling skills directly. Stipends for peer educators. Health camps include out of school adolescents, full health checkups and vaccinations. Letter box for anonymous questions, answers shared with everyone.	*ASRH Nutrition*	*Holistic / several*	*Both*	*Both*	*India*	*South Asia*	*p.17*
Ibid.	RH and nutrition for girls 11-14 in schools, emphasis on menstrual hygiene and knowledge about early marriage (so not really sexual health). All schools got posters, selected schools got 10 sessions and a 'health diary' . Diary was a key factor in success. Girls asked for a snack or a second helping (who would not have previously).	*ASRH Nutrition*	*Community-based*	*Prevention*	*Girls*	*India*	*South Asia*	*p.17*
WaterAid 2010, Menstrual hygiene in South Asia, a neglected issue for WASH, London UK 2010	Challenge of intergenerational engagement. India case study - menstruating women are shunned and separated. Saw giant leaps including the stocking of sanitary napkins and demand for them in local shops, as well as locally made cloth pads. Key target groups are girls and women as users of services; and boys and men for awareness-raising; NGOs and other WASH agencies, and health and education service providers (including government departments), to replicate approaches	*ASRH*	*Community-based*	*Both*	*Girls*	*India*	*South Asia*	*No*

Weiss et al. 2012, A Model for Sustainable Development of Child Mental Health Infrastructure in the LMIC World: Vietnam as a Case Example, International Perspectives in Psychology: Research, Practice, Consultation, 2012, Vol. 1, No. 1, 63–77	Vietnam case study. Schools make a starting point for identifying and referring children but the most vulnerable particularly in adolescence are not in school, they may even have been expelled. Longterm training of trainers rather than attempting to skill up paraprofessionals. Program components: graduate program, established partner research agency network, school-based mental health (partnership with govt), teacher training, outreach.	*Mental health*	*Provider-led*	*Both*	*Both*	*Vietnam*	*East Asia*	*p.16*
WHO (2007). Engaging men and boys in changing gender-based inequity in health: Evidence from programme interventions. World Health Organisation, Geneva	Program H in India, Brazil. Group education with weekly sessions lasting six months, different memberships over that time. Community level mass media campaign. Reduced STIs (Brazil), increased condom use, decreased harassment (India), both countries improved attitudes (confirmed by young female partners).	*ASRH Violence and injury*	*Community-led*	*Prevention*	*Boys*	*Brazil*	*Latin/South America*	*No*
WHO (2007(2)), Helping parents in developing countries improve adolescent health, World Health Organisation Geneva	A school-based programme called Expressions: The Comprehensive Life Skills and School Mental Health Programme. Separate workshops are held for parents that help them to understand various types of communication patterns with their adolescents. Specifically, parents are provided with practical solutions and tips for improving communication with their adolescent children, such as how to manage adolescents' argumentativeness and defiance. Parents have stated that they are now better equipped to recognize mental health problems among their adolescent children and to manage effectively their adolescents' behavioural problems.	*ASRH Violence and injury Mental health*	*Family, home, culture*	*Prevention*	*Parents*	*India*	*South Asia*	*p.21*
Woog V et al. (2015), Adolescent Women's Need for and Use of Sexual and Reproductive Health Services in Developing Countries, New York: Guttmacher Institute, 2015	Girls not visiting the doctor; girls who do are not told about family planning; post abortion contraception counselling not taken up. Successful text campaign Mozambique improved these indicators. Also included popular media. Knowledge and delayed sex outcomes.	*ASRH*	*Provider led*	*Both*	*Girls*	*Mozambique*	*Sub-Saharan Africa*	
Ibid.	Voucher programs for contraception (no thorough evaluation). Cash transfers for female students	*ASRH*	*Provider led*	*Treatment*	*Girls*	*Nicaragua*	*Latin/South America*	
WRC (2014), Women's Refugee Commission, Strong Girls Powerful Women, June 2014	Safe Space model as a way to protect and nurture girls' 'assets': being in school, having strong friendship networks and social affiliation, access to a place to meet peers, access to relations of trust, information about health, and financial literacy. Much of the current programming for adolescent girls is based on the theory of change that building girls' assets during early adolescence will translate to decreased experience of GBV, delaying first pregnancy and age of marriage, and greater labor market participation.	*ASRH HIV*	*Community based*	*Both*	*Girls*	*DRC*	*Sub-Saharan Africa*	*p.22*
WRC (2014), Women's Refugee Commission, Strong Girls Powerful Women, June 2014	Disability inclusion. The girls most in need are generally those least likely to access services and programs, including Communities need a process of education and buy-in, which is necessary as part of project start-up in order for women, men, and boys to "see" girls and their particular needs, importance, and potential as agents of change, including married girls, girls who are heads of households, and girls with disabilities. Reaching these girls requires additional effort and thoughtful outreach strategies. Community dialogue on responsibility	*ASRH*	*Home, family, culture*	*Both*	*Girls*	*Unspec.*		
WRC (2012), *Adolescent Sexual and Reproductive Health Programs in Humanitarian Settings: An In-depth Look at Family Planning Services*. WRC/Save the Children /UNHCR/UNFPA, Dec 2012	Mae Sot, clinic and youth centre, focused on girls, connected to referrals. Open day only but with emergency night manager. Discreet, safe recreational space, older peer educators.	*ASRH*	*Community-based*	*Both*	*Girls*	*Thailand*	*East Asia*	*p. 22*
Ibid.	Rwanda - longterm camp school. In and out of school adolescents, with drama programmes and referrals for family planning, premarital consultations and VCT services at the health center. The program has also established a team of peer educators for sensitization activities and condom distribution. Expanded VCT counsellors to talk about family planning.	*ASRH*	*Community-based*	*Both*	*Both*	*Rwanda*	*Sub-Saharan Africa*	*p.22*
Ibid.	Gulu. Straight Talk Foundation. With its cutting-edge combination of prevention approaches, "Talk + Services + Livelihoods," STF has been a critical contributor to empowering and building social networks among vulnerable adolescents.	*ASRH HIV*	*Peer led*	*Prevention*	*Both*	*Uganda*	*Sub-Saharan Africa*	*No*
Ibid.	6 clinics with focus on youth (10 - 24) plus mobile health brigade and transport for those who needed it. Adolescents helped with design, helping to ensure that the facilities were appropriate and would be used.	*ASRH*	*Community based*	*Both*	*Both*	*Colombia*	*Latin/South America*	*pp. 15, 22*

Annex 2: Bibliography – general references

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