World Vision
health and nutrition

A LESSONS LEARNED REVIEW OF ADOLESCENT HEALTH PROGRAMMING

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List of Abbreviations

AH	Adolescent Health
ADP	Area Development Plan
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour Change Communication
CBO	Community Based Organisation
CWB	Child Well-being
DME	Design, Monitoring and Evaluation
DRR	Disaster Risk Reduction
EARO	East Africa Regional Office
HIV/AIDS	Human Immunodeficiency Virus /Acquired Immune Deficiency Syndrome
H&N	Health and Nutrition
IEC	Information, Education & Communication
LACR/O	Latin America Caribbean Region /Office
LEAP	Learning through Evaluation, Assessment and Planning
MEER/O	Middle East and Eastern Europe Region/ Office
MNCH	Maternal Neonatal Child Health
MOE	Ministry of Education
MOH	Ministry of Health
NGO	Non-Government Organisation
NO	National Office
PDD	Program Design Document
RO	Regional Office
SARO	Southern Africa Regional Office
SO	Support Office
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infections
WASH	Water, Sanitation & Hygiene
WHO	World Health Organisation
WV	World Vision

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Executive Summary

The 7-11 health and nutrition (H&N) strategy successfully galvanized World Vision (WV) to re-focus on the first 1000 days of life and resulted in increased organizational capacity and more resources being directed towards health programming for mothers and young children. However the 7-11 strategy did not address adolescents. In 2014 the MNCH team identified concerns shared by national offices (NOs) about the field reality issues and gaps in programming guidance on adolescent health (AH), in particular preventing early pregnancy, poor reproductive health outcomes in adolescents, supporting adolescent pregnant girls and concerns re increasing HIV infections amongst adolescents. The role of the Hope Initiative with the focus on HIV prevention with adolescents is recognised as raising awareness on adolescent sexual and reproductive health (ASRH) within WV. At the same time the global health community also identified improving adolescent health, especially for girls, in the new Sustainable Development Goals (SDGs) and the new UN Global Strategy for women, children and adolescents. This led to the decision to conduct this review in order to inform the development of adolescent health guidance for NOs.

This lessons learned review used a survey and project document review. The survey design was based on current WHO AH best practice and recommendations. Requests to participate in the survey were sent to key National NOs health focal points, selected regional health managers and two support offices (SOs). Out of 52 respondents, 27 NOs were represented.

This report provides important evidence of our AH programming in WV and demonstrates the need for an AH strategy and guidance for the partnership. It is clear that many NOs already consider adolescents in their health programming, despite them not being included in the 7-11 H&N strategy. The 2014 child well-being (CWB) report indicates other sectors are clearly addressing their needs showing that 60% of National Offices are working with adolescents through youth clubs for skills building and 1.25 million adolescents have directly benefited from WV programming[1].

Of the 56 NOs who are currently implementing health and nutrition programming we found:

27 NOs including adolescents in overall strategy (this includes multiple sectors such as education as well as health)	**18 NOs currently including adolescents in Health Technical Approaches (3 NOs planning AH TAs in next 5 years)**	**15 NOs report having adolescent programming experience in the past 5 years (4 NOs are planning AH programming in the next 5 years)**

LACR NOs have the largest number of countries programming AH with the largest available documentation on projects and results, followed by East Africa NOs.

The survey results suggest that much of the current adolescent health programming has been occurring in rural contexts, although urban programs were featured, and with high rates of adolescent pregnancy, high HIV burden, high MMR/maternal morbidity and/or maternal deaths in the adolescent age group; and high rates of sexually transmitted infections (STI). Nutrition and violence were also important considerations for respondents. Health specific interventions most often reported by NOs included health education, comprehensive sex education and youth friendly services. Health sensitive

[1]WV's Child Wellbeing Report FY 14

interventions most reported included; education, vocational training, WASH and protection from violence.

Adolescent health policy and advocacy interventions were most often delivered through partners including Ministries of Health and Education, civil societies and NGOs. Policy and advocacy interventions most reported were birth and marriage registration, access to quality private confidential ARH services and creating opportunities for children's voices to be heard. While policy advocacy was done at national level, the local advocacy interventions were delivered in community centres, health facilities, and youth friendly centres, in partnership with adolescents, parents, community leaders and faith leaders.

Strategies and guidance are needed to support NOs to implement best practice AH interventions based on the WHO recommendations which includes a shift of thinking in the sector from focussing on adolescent-friendly projects and programs, to becoming adolescent-responsive programmes and systems.

Having curricula and programming guidance available to support comprehensive integrated adolescent programming is a priority. While sexual and reproductive health and HIV prevention programming remains a high priority, other health issues for adolescents arising as a result of violence, drug addiction and poor nutrition & life style, are also needed. Elements of adolescent health programming has tended to be integrated into other sectors, which potentially fragments strong comprehensive adolescent health approaches being implemented.

Orienting and updating staff on adolescent health programming priorities, and increased use of learning and reflection activities in projects and programs for increased understanding of the adolescent health programming experience for sharing across the WV partnership, are key recommendations.

Comments from Respondents

'Adolescents and youth are a large cohort of populations – it is critical to raise awareness with young people the consequences of early pregnancies and continue work on delaying marriage, family planning and issues around sexual health that have not been addressed in WV'

'In order to adequately address adolescent and sexual reproductive health programming there needs to be a clear mandate on how it will be addressed within WVI to ensure a clear sectoral focus and attention'

"Cultural considerations and action learning processes should be a part of adapting tools and curricula for particular communities for appropriateness and acceptability. Project staff may need support to ensure that their own attitudes and perceptions on adolescence are not barriers for change"

Introduction

The overall purpose of this preliminary report is to share findings on information collected to support a lessons learnt review of WV AH programming. Information collection was a two part process; part one was using a survey to collect information from NOs on their adolescent health programming experiences; part two was reviewing documents shared by NOs to identify successful approaches, models and evidence that could inform future adolescent health programming recommendations.

The results of the survey and the document review in this report are presented in the following sections:

1. Overall survey results - a descriptive summary of the responses of the survey with brief details of regional NO responses
2. Evidence of the results of the adolescent programming – a review of the documentation and reporting on results
3. Lessons learned – reporting on respondents comments, and reflecting on findings to inform recommendations
4. Appendices – detailed tables of collated survey results by NO regions and documentation review

Survey Method

Using the WHO adolescent framework as a guide[2], a survey instrument was developed to collect information on what NOs were currently doing in adolescent health (see appendices 4.1). Using survey monkey, two versions of the same survey of 33 questions were created in English and Spanish[3], and made available for respondents to access during July and early August.

The survey was conducted in July and August 2015 with a purposeful sample of staff from selected NOs, several regional offices (ROs) and two support offices (SO) who had knowledge or the responsibility of leading current or recent adolescent health programming or projects.

The survey was opened on July 3 and closed August 21. Spanish responses (11) were translated and added to the English responses (41). Completion rates varied considerably and 21 NOs have been included in the main body of the report having completed most of the questions, while 4 NOs did not complete all the questions (See Table 1). In total there were 52 respondents who represented 27 NOs, 4 ROs and 3 SOs and 1 global technical team. A response rate is not calculated as the number of people reached with the link to the survey was not known.[4]

Documentation Review

A number of documents provided from respondents included project reports, presentations, evaluations, project proposals and curricula examples. They were in several languages including English, Spanish, German, French and Portuguese. Documents were reviewed for 14 projects covering 17

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[2] WHO (2014), 'Health for the worlds adolescents- a second chance in the second decade',
[3] Due to limited time and staffing factors a decision was made not to translate the survey into French
[4] Some staff were on leave during the survey period and in several instances the survey link was shared beyond targeted staff.

NOs, and curricula developed by 3 NOs[5] (see appendices 4.13). Documents were uploaded into Nvivo[6] and reviewed for any common themes on challenges successes or lessons learned. Reviewing the documents was intended to see if there was further information available that could help inform the survey results. Given the diverse nature of the documents, it was not possible to do any comparative assessment however examples have been used to highlight particular areas.

Limitation

While this report does not reflect all possible AH programming across the partnership, the survey has provided an opportunity to collect information from a range of staff across all regions with experience or knowledge in implementing adolescent health programs. There are limitations on the quality of the shared information, purposeful sampling design of the survey, low response rate, potential translation errors, and lack of consistency of indicators used in projects. This created difficulties in making strong recommendations on the best interventions that worked across the partnership. As such this report is not intended to be used as a standalone document and should be considered along with the AH literature review currently in progress.

[5] Approximately 32 documents were provided however several documents were in a pdf format that were not able to be translated with full text, which limited the review for some projects to key sections of reports and presentations.

[6] NVivo is a qualitative data analysis (QDA) computer software package which is used for qualitative research as a tool to sort and analyse text based information.

Section 1 - Overall survey results

1.1 National Office Strategy & Adolescent Health programming experience

There were 52 respondents in the survey and they represented 27 National Offices (NOs) listed in Table 1 below. Four Regional Offices of LACRO, MEERO, SARO and EARO (4 respondents) were also represented as well as three support offices in US, Germany & Australia (3 respondents) and one respondent from the Global Technical Team (Humanitarian Operations).

The Latin American and Caribbean region reported the most national offices programming adolescent health, along with providing the most documentation of projects and results, followed by the East Africa region. As shown in Table 1 below, fifteen (15) NOs indicated they had adolescent programming experience in the past 5 years while six (6) NOs reported no adolescent programming experiences. Four (4) NOs are planning to do adolescent programming in the next 5 years.

Table 1 Responses from National Offices in regard to having adolescents included in their national strategy, health technical approach[7] and programming (Y: Yes, N: No)[8]

National Offices	Completed Qs	NO Strategy	Health TA -now	Health TA - future	AH programming-past 5 years	AH Programming –next 5 years
East Africa						
Ethiopia	Y	Y	Y		Y	
Kenya	Y	Y	Y		Y	
Uganda	Y	Y	Y		Y	
South Sudan	Y	Y	Y		N	Y
Rwanda	Y	-	N	Y	Y	
Sudan	Y	Y	-		-	
Burundi	Y	Y	Y		Y	
Middle East/Eastern Europe						
Lebanon & Syria	Y	Y	Y		Y	
Jerusalem West Bank Gaza	Y	Y	Y		Y	
East Asia						
Cambodia	Y	Y	N	-	N	N
Mongolia	Y	Y	Y		N	
Thailand	Y	Y	Y		N	Y
Latin America/Caribbean						
Unnamed country*	Y	Y	Y		N	Y
Bolivia	Y	Y	Y		Y	
Mexico	Y	Y	N	Y	Y	
Nicaragua	Y	Y	Y		Y	
Honduras	N	Y	Y		Y	
Ecuador	N	-	-			
Dominican Republic	Y	Y	Y		-	
Peru	Y	Y	Y		-	

[7] WV is currently implementing LEAP 3 in national offices which aligns technical approaches with strategic objectives. Some NOs are still developing their technical approaches for approval.
[8] As the survey was developed for NOs, responses from ROs, global teams and support offices have not been included in this table.

South Asia & Pacific						
Unnamed country*	Y	Y	N	Y	Y	
Sri Lanka	N	N	-			
India	N	N	-			
Philippines	Y	Y	Y		Y	
West Africa						
Senegal	Y	Y	Y		Y	
Southern Africa						
Zambia	N	-	-			
Lesotho	N	N				
Swaziland	Y	Y	Y		Y	
South Africa	Y	Y	N	Y	N	Y

**several respondents indicated their region rather than National Office in the survey*

1.2 Programming Sectors for adolescents

National Offices strategies, which included adolescents, covered a range of sectors, however, the dates and descriptions of strategies were generally not provided. In Table 2 below, responses are grouped by regions. Adolescents are included in a number of sectors, which reflects the diverse settings, contexts and priorities of NOs (see appendices 4.5.2). Education was the most often listed sector by NOs (13) followed by health (7), sexual and reproductive health (5), Economic (5) and child protection (4). These sectors were a mixture of standalone and cross cutting.

Table 2 National Office strategies sectors which include adolescents by regions

East Africa		**Latin America/Caribbean**	
Ethiopia Kenya Uganda South Sudan Rwanda Burundi	COH Improved access & quality education Life skills (3) ECCD & Education with infrastructure development Economic development (2) Economic preparation & livelihoods Education (3) Food security for economic empowerment Improved protection Increasing access to reproductive health services Livelihoods and health Primary health care services Quality improvement in Community Development Reproductive health Vocational training and life skills	Bolivia Mexico Nicaragua Honduras Dominican Republic Peru	Active citizenship (2) Advocacy (2) Citizenship Economic development Education and economic development. Education and life skills Entrepreneurship Health HIV Life skills (4) Parenting with tenderness Participation Prevention of social risks and life skills Protection (2) Sexual and reproductive health (2) Sexual and reproductive health and education Reproductive health and education
Middle East/Eastern Europe		**East Asia**	
Lebanon & Syria Jerusalem West Bank Gaza	Child protection Education and Life skills Education - sky clubs Education & leadership Health	Cambodia Mongolia Thailand	Child Protection Education Life skills in Health, education and economic Health sector - government
South Asia & Pacific		**Southern Africa**	

Philippines & Other	Econ Dev Education - Life skills Health Health- HIV and AIDS Nutrition RDD WASH	Swaziland South Africa	Child Protection Economic development Education (2) Health Life skills
West Africa		**Other**	
Senegal	Child Protection Education Food Security	Australia Program	Life Skills - Culturally centered

1.3 Adolescents and health technical approaches[9]

Seventeen (17) respondents indicated they included adolescents in their health technical approaches. Approaches included health system strengthening, improving access to or capacity building in health services (4), HIV (4), nutrition (4), reproductive health (3), sexual and reproductive health (3), adolescent sexual and reproductive health (2), health (2), teen pregnancy prevention (2), while the remaining areas were advocacy, BCC & knowledge improvement, communicable diseases, community empowerment, congenital malformations, disabilities, economic development, education, gender, livelihoods, reducing violence, resilience, substance abuse and youth friendly services (see appendices 4.2).

1.4 Adolescent health programming context

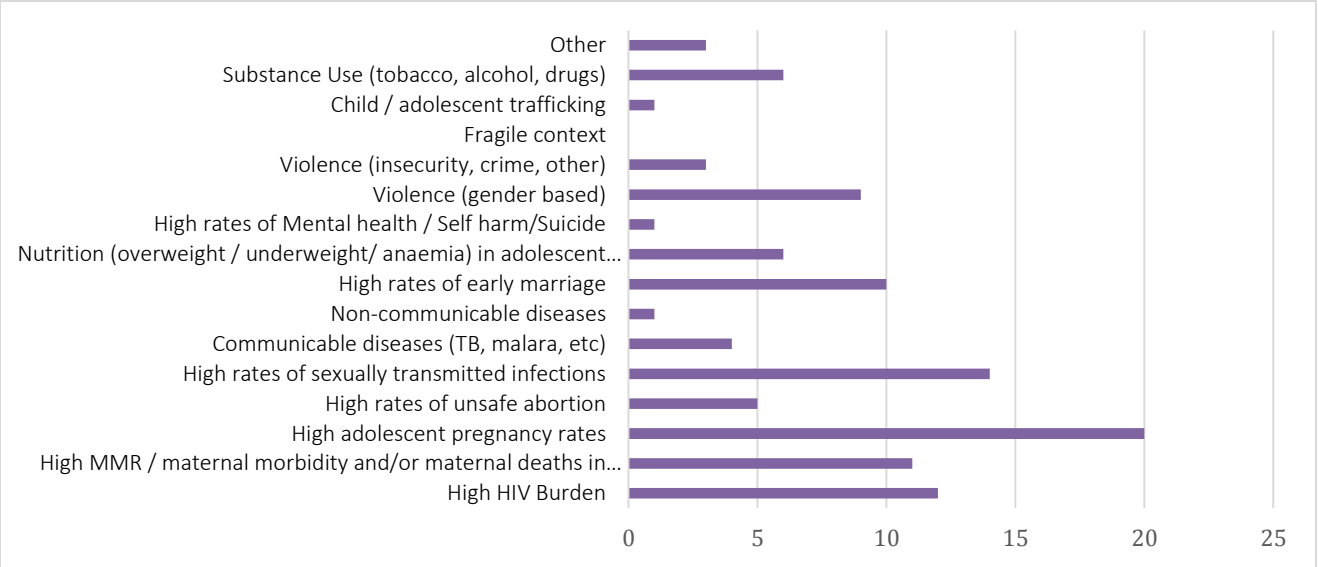
NOs were asked to identify programming contexts and rank in order of priority. Responses for the top 5 ranked priorities for each NOs are combined together in graph 1.

The highest priorities were identified in the following order; high adolescent pregnancy rates (20) high rates of sexually transmitted infections (14), high HIV burden (12), high MMR / maternal morbidity and/or maternal deaths in adolescent age group (11), high rates of early marriage (10), violence (gender based) (9), nutrition (overweight / underweight/ anaemia) in adolescent girls age group (6) and substance use (tobacco, alcohol, drugs) (6) (see appendices 4.3).

In terms of regional focus; the Latin America and Caribbean NOs identified high adolescent pregnancy, high MMR and violence as highest priorities; East Africa NOs placed high adolescent pregnancy rates, nutrition and substance abuse as their highest priority programming context; Middle East/Western Europe identified substance abuse and nutrition as highest priorities; Sth Asia & Pacific region has HIV, high MMR and nutrition; Southern Africa NOs HIV burden, high MMR, high pregnancy rates and nutrition; while East Asia has high rates of adolescent pregnancies and high rates of STIs. West African NO adolescent health programming context is not represented as completion of this question was incomplete.

[9] Some NOs are still developing their technical approaches for approval, so for some NOs this is provisional information.

Graph 1. Priority areas (1-5) relevant for adolescent programming context ranked by NOs.



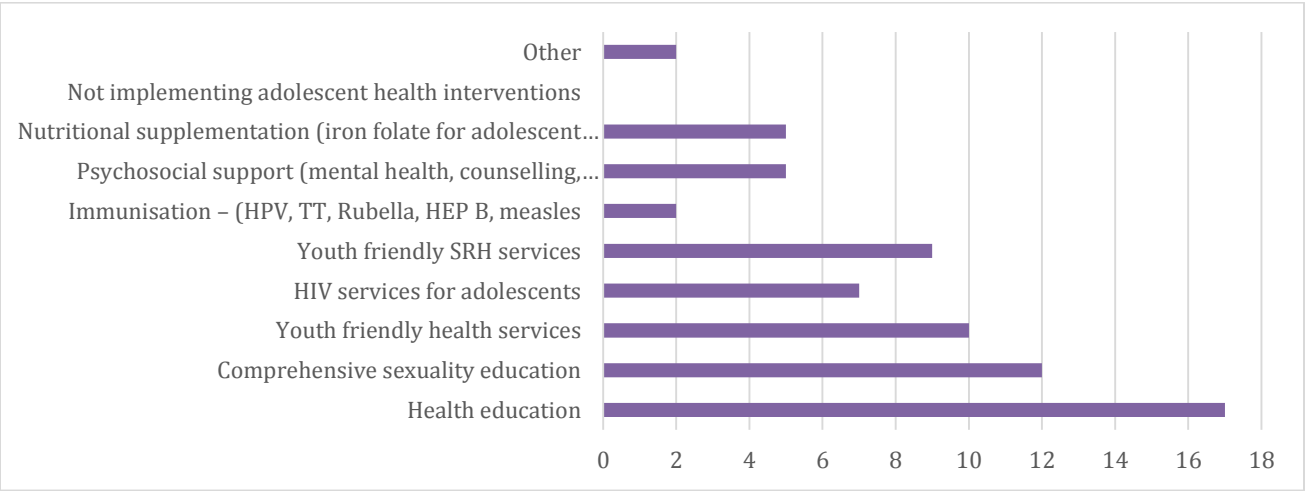
X axis indicates number of NOs

1.5 Adolescent health specific Interventions

NOs indicated that the most common health intervention for adolescents they were using were health education (17), followed by comprehensive sexuality education (12), youth friendly services (10), youth friendly SRH services (9), HIV services for adolescent (7), psychosocial support and nutritional supplementation (5) and immunisation (2) and other (2) (behaviour change) (see graph 2 below).

Southern Africa and East Africa regions NOs most often reported interventions were health education, youth friendly health services, HIV services for adolescents and youth friendly SRH services. LACR region NOs more often reported using comprehensive sexuality education and health education interventions (see appendices 4.4).

Graph 2. Adolescent health specific interventions reported by NOs.



X axis indicates number of NOs

When asked to comment on their health interventions and approaches, LACR NOs had the strongest focus on addressing adolescent sexual and reproductive health, drug and alcohol issues using life skills development and empowerment approaches, combined with improving access to youth friendly primary health services. This approach was also mentioned for addressing drug and alcohol issues for Middle East / Eastern Europe and South Asia. East Africa also included this approach for HIV interventions as well as youth friendly services.

Descriptions of health interventions included training health workers and establishing youth friendly services, developing youth peer groups, conducting capacity building opportunities to increase knowledge and skills on adolescent health, providing health or sex education, by working with schools and teachers and community partners to increase knowledge on sexual and reproductive health, substance and alcohol abuse and smoking, diet or nutrition, strengthening referral mechanisms between adolescents and health services, establishing crises help line or counselling services, and building of positive relationships with peers and family, and working in advocacy with government ministries to improve policy environment for adolescents.

1.6 Health Sensitive Interventions

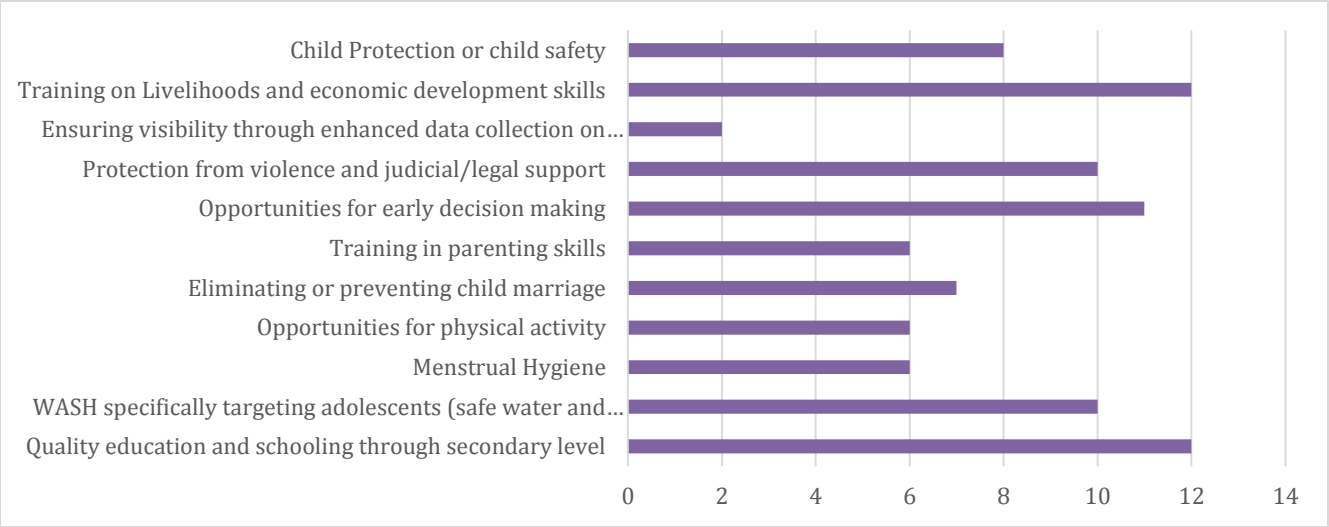
Adolescent Health Sensitive Interventions refers to those that are known to indirectly impact on adolescent health outcomes, similar to UNICEF's nutrition sensitive interventions, which are defined differently to nutrition specific interventions.[10]

NOs were asked what specific adolescent health sensitive interventions they were using (see Graph 3). Quality education and schooling through secondary level (12) and training on livelihoods and economic development skills (12), opportunities for early decision making (11), protection from violence and judicial/legal support (10) and WASH specifically targeting adolescents (safe water and sanitation at school and home (10) were the most often mentioned health sensitive intervention. They were followed by child protection or child safety (8), eliminating or preventing child marriage (7), training in parenting skills (6), opportunities for physical activity (6) and menstrual hygiene (6). Ensuring visibility through enhanced data collection on adolescents (2) was mentioned by both Latin America and East African regions.

There was some variation between the regions on the health sensitive interventions. East African NOs indicated they were implementing most of the health sensitive interventions, with the exception of creating opportunities for physical activity. LACR reported NOs implementing most of the listed interventions but not menstrual hygiene, eliminating or preventing child marriage, or training in parenting skills (see appendices 4.5).

[10] Ruel, M, (2013). Nutrition-sensitive interventions and programmes: how can they help to accelerate progress in improving maternal and child nutrition?The Lancet, Volume 382, No. 9891, p536–551.

Graph 3 Adolescent health sensitive interventions reported by NOs

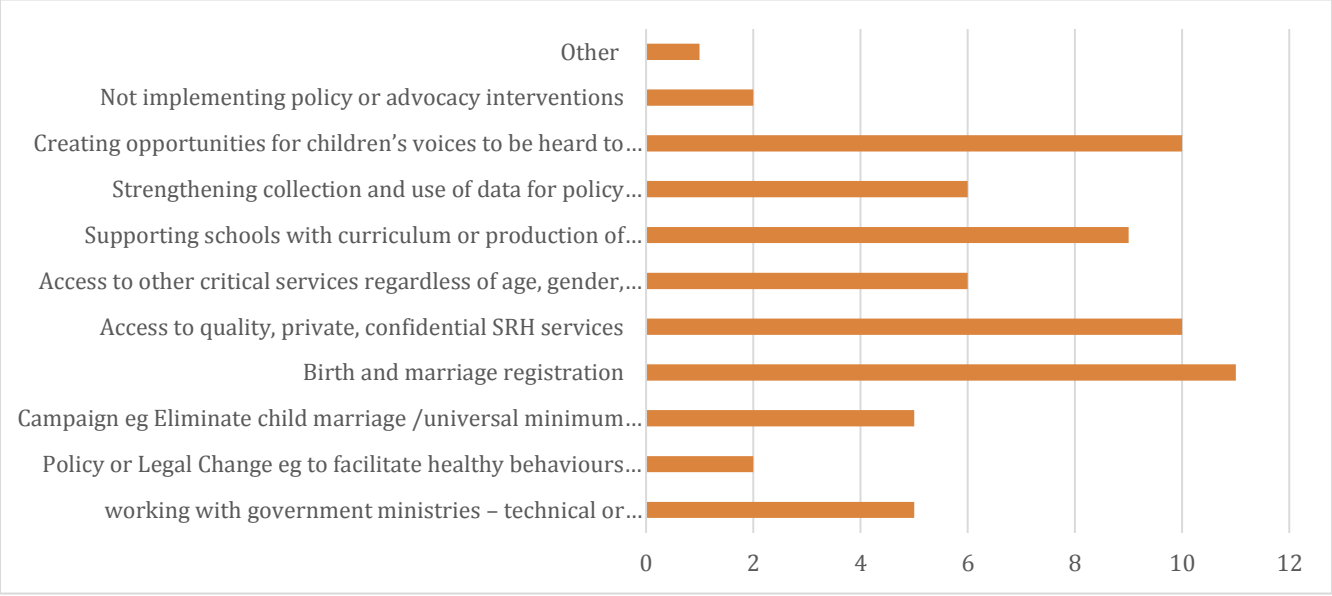


X axis indicates number of NOs

1.7 Types of Policy & Advocacy Interventions

NOs were asked to indicate types of policy and advocacy interventions they were currently supporting. East African NOs reported using all the interventions listed below (see Graph 4) while Latin America NOs reported using most of the interventions except working groups with government ministries, policy change or child marriage campaigns. The MEER NOs reported not currently using policy or advocacy interventions in adolescent health (see appendices 4.6).

Graph 4 Policy and advocacy interventions reported by NOs



X axis indicates number of NOs

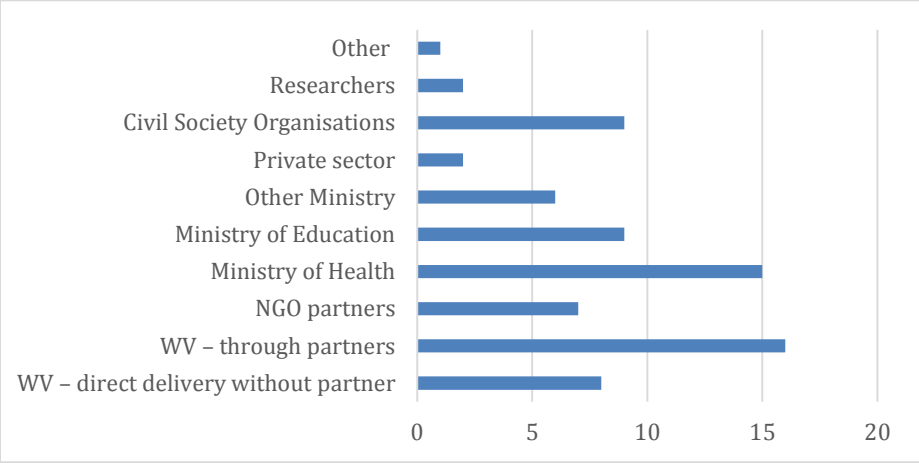
When asked to comment on the type of policy and advocacy interventions they were using, a range of areas were mentioned including adding awareness and capacity building around early marriage and births

registration, developing adolescent friendly health policies, accreditation of health services in partnership with the community, strengthening curricula activities in SRH, health and child protection, and working with the judiciary and law enforcement agencies on drugs and controlled substance and age and sex. Also mentioned was increasing children's voices to be heard by local leaders and legislators in communities.

1.8 Policy and adolescent health interventions delivery

Most of the NOs reported delivering their policy and adolescent health interventions through partners[11] (16), closely followed by Ministries of Health (15) (see graph 5). With the exception of East Africa and Southern Africa regions, remaining NOs reported delivery interventions through civil society organisations (9). Ministry of Education (9) was also reported by most NOs. South Asia NOs reported delivering their interventions using all the items listed, and was the region most often using direct delivery without a partner (8). The remaining delivery of health interventions included NGO partners (7), Other Ministries (6), Private sector (2) , researchers (2) and Other (1) (schools) (see appendices 4.7).

Graph 5 adolescent health interventions delivery reported by NOs



X axis indicates number of NOs

1. 9 Place of Intervention

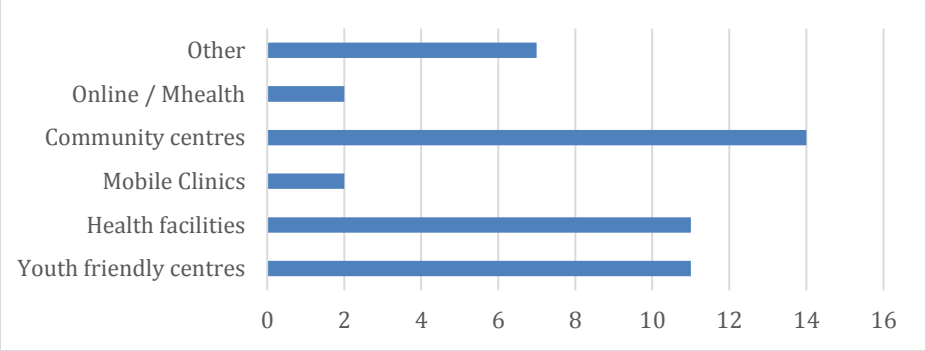
NOs were asked to provide information about where the adolescent health interventions were taking place. Community Centres were the most often mentioned location (14), followed by Health Facilities and Youth Friendly centres (11) and other (7). These included secondary schools, emergency relief centres, youth clubs and call centre. Online / Mhealth (2) and mobile clinics (2) were also used (see appendices 4.8).

East African NOs reported that interventions were mostly occurring in health facilities (5), youth friendly centres (4) and community centres (4). LACR NOs reported most interventions were occurring in 'other' category (5) which included schools, youth clubs, call centre & secondary schools, followed by youth friendly centres (4) and community centres (4) and health facilities (3). South Asia NOs reported

[11] Partners refers to organisations that deliver health program interventions while Ministries of Health and Education and other government bodies deliver policy interventions.

most interventions were in community centres (4) and health facilities (2). Middle East/Eastern Europe NOs interventions were youth friendly services, schools and emergency care and relief centres.

Graph 6 Places of and adolescent health interventions reported by NOs

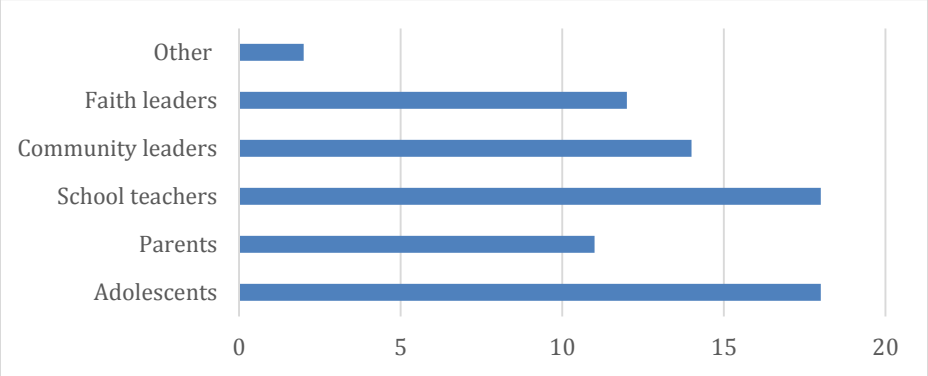


X axis indicates number of NOs

1.10 Intervention partnerships

Every NO indicated that interventions were occurring in partnership with adolescents (18) and school teachers (18). This was followed by community leaders (14), faith leaders (12), parents (11) and other (2) (government technicians and community health workers). All NOs reported partnerships with most of the items listed below, with the exception of Middle East/Eastern Europe reporting not using faith leaders, and South African NO not using parents and community leaders.

Graph 7 Intervention partnerships reported by NOs

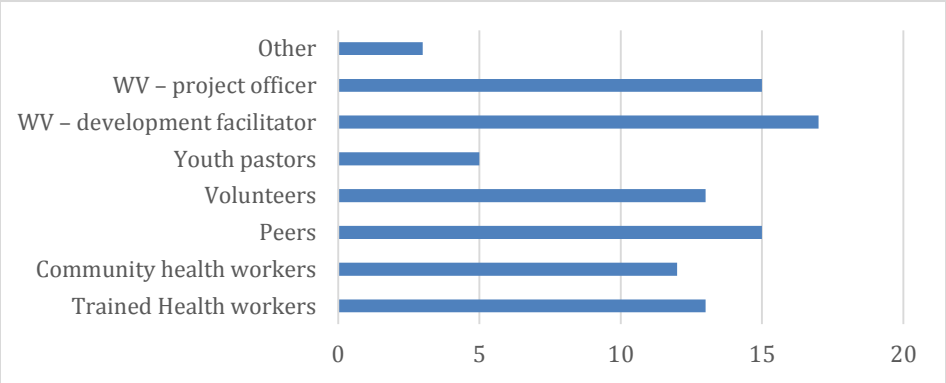


X axis indicates number of NOs

1.11 Cadre of staff delivering the program

The NOs reported that cadre of staff most often delivering the program was the WV development facilitator (17), followed by WV – project officers (15), peers (15), trained health workers (13), volunteers (13), community health workers (12), youth pastors (5) and others (3) which included peer educators, health and education ministerial staff and trained school teachers (see appendices 4.9).

Graph 8 Cadre of staff delivering the program reported by NOs

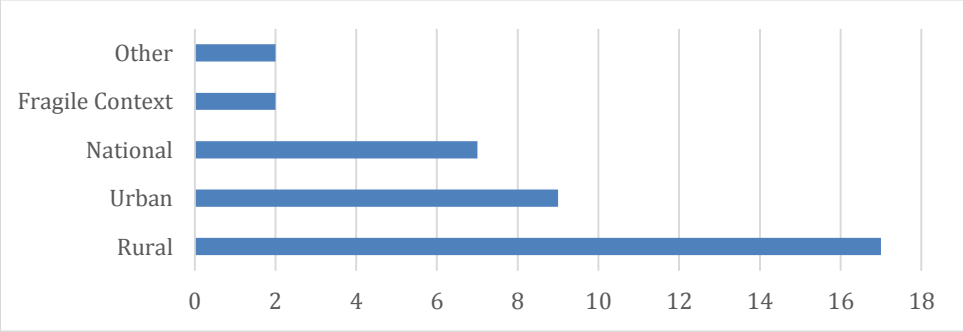


X axis indicates number of NOs

1.12 Setting of the adolescent health programming

Most NO regions reported programming in rural, urban and national contexts. The largest reported context was rural (17), followed by urban (9) and national (7). Fragile contexts were reported by 2 NOs, and other (2) (combination of settings). Most NOs reported programming in at least two of those contexts with the exception of NOs Burundi, Ecuador and Nicaragua which reported only operating in the rural context. NOs Dominican Republic and Jerusalem West Bank Gaza reported programming in a fragile context setting (see appendices 4.9.2).

Graph 9 Setting of adolescent health programming reported by NOs



X axis indicates number of NOs

1.13 Funding of the adolescent health programming

Most NOs reported using ADP funding (14), followed by grant funding (11) and other funding (6) for their adolescent health programming.

Examples of funded projects from respondents include; E FACE, Preventative Care Package, Sponsorship projects, HIV& AIDS programming, youth and adolescent projects, school health committees, RAMBA project, First Infant Health (Child Health Now) Campaign, SRH, HIV/AIDs & STI prevention, ADPs incorporating adolescent programming, Voice and action and education for life, Rangers Youth Health 'light chains' project, models of learning SRH education and life skills to prevention HIV, Nutrition Initiative Project, Integrated Programming for Child Health, HIV prevention projects, and improved maternal and child health projects (see appendices 4.10).

1.14 Indicators used for reporting of adolescent health programming

NOs (13) reported using indicators in the project but only 5 NOs provided specific details. Examples of indicators provided by NOs could generally be grouped into monitoring training or participation at events (individual, community, and peer) or advocacy at regional or national level. Several respondents commented on indicators and reporting being based on donor and grant requirements on process, results and impact indicators. For example indicators were used to report on condom use, abstinence, delayed sexual debut, use of drugs / alcohol, score of life skills, as well as providing information to government partners on health and nutrition and services provided by the project (such as iron folate supplementation, menstrual hygiene education, and activities to encourage delaying marital age).

One NO suggested that current indicators are dated and strongly recommended developing indicators that reflect current issues for adolescents e.g. technology / mobile phone era impacting on adolescent life and behaviour. In 2014, WV published a guide to using the Youth Health Behaviour Survey[12] to improve reporting on adolescent health programming. It is expected that with time more NOs will both use and publish experiences of using this tool.

Table 3. Indicators

Individual or family level changes in knowledge, skills, perceptions, behavior or attitudes	% of technical health staff with improved knowledge on SRH and substance abuse topics % of youth girls / boys who can identify 2 key messages of the trainings received % of adolescents who have correct knowledge about modes of transmission and prevention of HIV % youths who reported an increase in self-care (disaggregated by gender) % of youth aged 12 - 18 who reported an increase in their personal development asset profile (disaggregated by gender) % children and adolescents who have risk behaviors decreased to STIs, HIV and AIDS (first sexual intercourse, condom use in sex, more than one sex partner, use of alcohol and drugs on sex) % children and adolescents who mentioned their fathers and mothers address the issue of STIs, HIV and AIDS with them % of children and adolescents who mention at least 2 prevention and transmission methods of STIs, HIV and AIDS.
Community events or reports	# capacity building events attended # community Reports (Substance abuse prevention and SRH) finalized # ADP level trainings delivered
Peer to peer training and participation	# trained youth % of youth boys who regularly attend the trainings % of youth girls who regularly attend the trainings # trained TOT in life skills (HIV prevention and adolescent reproductive health) # clubs formed in and out of schools # of committed youth boys recruited # of committed youth girls recruited

[12] The Youth Healthy Behaviour Survey is a quantitative tool for use with children and young people aged 12 – 18 years, both in and out of school. It is designed for use at baseline and evaluation to provide before and after comparison of indicators of child wellbeing with groups of children, and is not to be used for one to one interviews. It has modules on physical violence, sex and relationships, smoking, alcohol, hygiene, HIV and community participation.

	# adolescents who received training by their peers in SRH and HIV # promoters that implement the methodology for life skills (disaggregated by gender)
Advocacy	# of IEC materials developed # of signed MOUs with youth groups at the national level # of national events organized with partners # of meetings held with national and local level religious leaders # national workshops # of communication and education material developed
Regional or National data	# Adolescent Pregnancy Infant Mortality Rate

Section 2 - Evidence of the results of the adolescent programming

2.1 Project documentation available

To help identify existing evidence available, survey respondents were asked if they had collected any results of their adolescent programming experiences. A number of NOs (9) and several ROs (2) and a support office (1) indicated they had collected information on adolescent programming. Of those respondents, 6 indicated having presented or publishing this information to audiences. This was in the form of baselines (3), evaluation reports (1), and project reports (1) and online reporting system called CHARMS (1) that captures indicators on HIV and life skills. 2 NOs reported they were in the process of collecting information for evaluations (see appendices 4.10). One NO reported a challenge of having project documentation in local languages made sharing difficult.

Regional advisors were provided with documents from some of the NOs, which were made available for this review. Documents shared on adolescent health programming experiences from the past 5 years included some NOs who had not participated in the survey. To help capture more recent reporting on adolescent programming experiences they were included in the documentation review. (See table 4 below for the documents provided).

Table 4. Document Review

1	Afghanistan	Evaluation Report - Support for Street Children (SFSC) in Herat Project, World Vision Afghanistan, July 2014
2	Armenia	Improved Maternal and Child Health in Armenia ADP Proposal 2010 – 2015
3	Bangladesh	End Evaluation Report - Juvenile Delinquents Project (B-176541) April 2014
4	Bolivia	Special Project - HIV prevention and AIDS, "Chain of Light" 2010
5	Brazil	Systematization Methodology Healthy Maternity Healthy - Assorted documents and resources
6	Burundi	RAMBA Project (B201527) Project documents relate to HIV Prevention among Children and Youths Project in Burundi
7	Dominican Republic	Evaluation report - Project: Operational Model of HIV Prevention in Children and Adolescents and Youth, October 2010
8	Haiti, Kenya & Tanzania	Abstinence and Risk Avoidance for Youth Project Report (ARK). End of project evaluation for Haiti, Kenya and Tanzania 2010
9	Honduras & Dominican Republic	Final Evaluation Report - Pilot Project for the HIV Prevention Model in Children, Adolescents and Youths between the Ages of 5 to 18 years, based on Life Skills and Sexual and Reproductive Health

		Education, implemented in Honduras and the Dominican Republic 2010
10	Indonesia	Final Report -Vocational Training Centre Report 2010-2014
11	Kenya	End of project evaluation - Youth Channels and Agents of Change, July 2015
12	Mexico	THE CHALLENGE. Adolescent Welfare Promotion – facilitator training guide
13	Nicaragua	Final Report - Special Program Final Evaluation "Promotion of Sexual and Reproductive Health with emphasis on HIV, Suina June 29, 2014
14	Peru	Project Design Document - Complementary Project. "Building a Healthy and Responsible Sexuality" 20 May 2009 (Strategy for training adolescent peer educators on healthy sexuality)
15	Sierra Leone	HIV Prevention among Children and Youths Project, 2009
16	Solomon Islands	End of Project Evaluation - Honiara Youth Development, Employment and Small Enterprise Project (HYDESEP) Oct 2014

2.2 Review of adolescent health programming

Review of the project documents was intended to find examples of effective adolescent health programming experiences and approaches, and to complement the survey information. It was not intended to demonstrate all WV adolescent programming experience by NOs (for example adolescent programming experiences for emergency contexts is not included).

Project designs included elements of HIV prevention, life skills development and adolescent sexual and reproductive health, and community development (see appendices 4.13). The focus of the project sectors included in the project documents included;

- Adolescent sexual and reproductive health (2)
- Peer education training curriculum (2)
- HIV prevention (4)
- HIV prevention research
- HIV prevention, care & treatment
- HIV prevention, SRH education (2)
- HIV prevention, SRH
- Juvenile justice (2)
- Maternal and child health
- Vocational training (2)
- Youth leadership
- Youth leadership & SRH education (COH MNCH)

2.3 Reporting on project outcomes

Adolescent health programming activities undertaken and reported by projects were either 1) to support specific health issues, for example, ensuring that pregnant teenagers received adequate antenatal care or could access youth friendly services, or 2) health was a cross cutting issue that needed to be addressed, such as in a child protection framework where children in juvenile justice system often had considerable health needs (both physical and psycho -social) as well as street children in areas affected

by insurgency or fighting.[13],[14] This made outcomes difficult to assess as well as identifying clear factors that could be enablers or disablers of successful programming.

Examples of successful adolescent sexual and reproductive health projects being implemented from the document review appears best documented with the LACR projects. There has been encouraging early positive impact for many beneficiaries at the individual level but less clear evidence of impact at community level as projects need sufficient time to consolidate and support long term change. Several projects are listed in table 5 below (see appendices 4.13 for a case study example).

Table 5. Projects showing positive change for adolescents

Project	Activities	Outcomes
Brazil - Systematization Methodology Healthy Maternity, April 2011	Improved antenatal care and attendance of pregnant teenagers, with use of personal development plans, increased support and educational activities.	Project reported achieving a reduction in malnutrition and improved low birth weights in infants of adolescent mothers.
Nicaragua - "Promotion of sexual and reproductive health with emphasis on HIV" Suina, June 2014.	Use of community awareness campaigns, peer educators, used COH approach with local leaders emphasizing HIV prevention and focus on Christian values, responsible sexual behaviour and life skills.	Project reported a 2% pregnancy reduction and modest increase in condom use (7.8%). The reduction in pregnancy appears to have been achieved through increased use of contraceptives by teenagers.
Dominican Republic - Operational Model of HIV prevention in children, adolescents and youth, October 2010.	Social learning methodology working with adolescents to co create and develop appropriate messaging and information on HIV prevention and SRH materials, by use of leadership and citizenship activities and building child and youth networks.	Adolescents and youth self -reported 40% reduction in the prevalence of sexually active adolescents, 70% reported decrease of sexual activity in the previous 12 months (secondary abstinence) and a one year delay with the initiation of sexual activity.

Most of the HIV prevention projects reported increased knowledge and awareness of HIV transmission with improved attitudes (reduced stigma) towards HIV positive individuals[15],[16],[17]. Projects used process indicators to report on progress towards change e.g. number of participants in a community reached with messages or interventions or counselling. Evaluations of impact relied on detecting changes of knowledge and skill for adolescents which was usually based on self-reported changes by participants, or by asking specific questions on topics such as ways HIV can be transmitted to measure knowledge

[13] Evaluation Report – Support for Street Children in Herat, Afghanistan, July 2014.
[14] End of Evaluation Report – Juvenile Delinquents Project, Bangladesh, April 2014.
[15] Special Project HIV prevention and AIDS 'Chain of Light', 2010
[16] Evaluation Report – Project ; Operational Model of HIV prevention in Children & Adolescents and Youth, Dominican Republic, October 2010
[17] Abstinence and Risk Avoidance for Youth Project Report (ARK). End of project evaluation for Haiti, Kenya and Tanzania, 2010

changes, using tools such as sexual health life skills scores[18], interviews, household surveys and use of focus groups and other secondary data for qualitative information.

There were two HIV projects with a similar design being implemented differently in different countries[19],[20], with projects having different staffing, training and local partner arrangements which has made comparison of project achievements and learnings difficult. Some of the projects experienced challenges around some of the cultural considerations and sensitivities of HIV transmission when implementing training or awareness raising events, for example in discussing sexuality or issues such as condom use. Developing peer support networks for HIV positive adolescents has been an important outcome where adolescent friendly essential services were not available. However using youth peer support approaches can be difficult in unstable contexts when adolescents and families are highly mobile[21].

2.4 Data collection challenges

Data collection has been a consistent monitoring and evaluation challenge for most projects when youth are highly mobile and transient participants, and when there is turnover of project participants and staff. In particular, peer to peer education models and teen clubs rely heavily on teens taking up leadership roles and volunteering which leads to fatigue of managing demands of keeping youth mobilised with subsequent turnover of team leaders and loss of training skills to the group.

While teenagers report they will delay initial sexual activity, evidence for this occurring is not readily available as there is always a lag on district, regional and national data collection on key indicators which may become evident after a project has finished. Some of the larger projects evaluated rely on measuring a sample of adolescents knowledge, attitude, perception and behaviour changes over a period of time, and while useful in showing some change, controlling for a range of factors was problematic, if there were other initiatives that occurred with the same community such as a government initiative, or lack of control communities for comparison.[22],[23]

One project evaluation highlighted a challenge of adequately defining 'life skills' in the initial project design, which then made evaluation challenging. For example the vocational project evaluation commented on project staff 'that they did not know whether the term life skills referred only to "soft skills" such as time management, anger management, leadership and decision-making or whether life skills also included technical skills such as fabric dying, sewing-machine maintenance and pattern drafting".

Several projects reported using a faith lens for training on life skills, building hope horizons and increasing access to adolescent friendly services which was well received by church communities and leaders. The channels of hope (COH) and citizen's voice and action (CVA) methodology can support long term embedding of improving knowledge and behaviour change beyond project parameters,

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[18] Final Evaluation Report Piloting Project Model HIV Prevention in Children and Adolescents 5-18 age, based on Life Skills and Education Sexual and Reproductive Health, implemented in Honduras and Dominican Republic, Aug 2010

[19] Abstinence and Risk Avoidance Project (ARK) 2010 in Haiti, Kenya and Tanzania

[20] Pilot project for the HIV prevention model in children, adolescents and youths, 2010, Dominican Republic and Honduras

[21] Pilot Project for the HIV Prevention Model in Children, Adolescents and Youths, 2010, Honduras and Dominican Republic

[22] ARK project, Haiti, Kenya and Tanzania, Evaluation, 2010

however they require community capacity building to get established and sufficient time should be allowed for this (1-3 years) before programming for adolescents can show results.

Some of the data collection challenges described in the projects reviewed, are also captured in WV's child wellbeing reporting. For example the 2014 CWB report indicated that 60% of NOs are working with adolescents through youth clubs for skills building, and 1.25 million adolescents have directly benefited from WV programming. Some challenges in the reporting on target 1 – Children report an increased level of well-being (ages 12 -18) included incorrect use of tools Development Assets Profile (DAP), Youth healthy behaviour survey on 1-4 indicators, and qualitative methods by NOs.

Other comments included;

- *Data is being collected (by national offices) that doesn't relate to the specific target groups or programming interventions. This leads to confusion about what the data is telling us and how to use it.*
- *The findings raise questions that are not answered by the Child Well-being Reports such as why certain adolescents or areas within the same country score lower on specific scales: who are these adolescents? Why do they feel the way they do about their lives? How does gender, ethnicity, disability or other vulnerability factors affect these issues?*
- *The evidence is challenging national offices to take action, but programming models and appropriate responses are still underdeveloped. There are promising practices particularly in MEER and LACR, but more information is needed about the obstacles that prevent NOs from better addressing the issues.* [24]

2.5 Adolescent participatory and peer learning approaches

Adolescent and youth empowerment models focused on peer to peer training and increasing education and work opportunities by using life skills, creating opportunities, access to positive role models, knowledge and skills development. Participating in peer-based programs appears to be well associated with the development of important assets: increased self-esteem and confidence through helping others and being asked for help, increased awareness of personal strengths and potential, work experience and life skills and increased self-efficacy and belief in personal ability to access help/help others. (The use of the Developmental Assets Profile tool (DAP) is intended to measure some of those elements[25]).

This approach was evident in a number of projects. For example, the faith based life skills curriculum referred to by several projects in Latin America programs referred to a *'constructionist theoretical underpinning; for the life skills intervention to be effective, it is necessary to clearly establish the objectives of each lesson. Learning is facilitated by the use of listening, observation, role playing, and practising using the skills as well as reflecting on the learning. The adolescent must be supported in order to feel sure of applying these skills even in higher risk situations'*. Several projects also described of using participatory learning approaches to develop curricula and materials for training adolescents, which provided engagement and participation opportunities for adolescents in decision making. While the approaches were described, the quality of the training in projects provided was not always evaluated.

STI/ HIV frameworks were described using individual-level interventions that targets risk factors attributable to individuals, such as counselling, screening and treatment to create behaviour change, and

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[24] WV's Child Wellbeing Report FY 14

[25] Developmental Assets Profile® (DAP) The tool measures assets across environments (personal, social, family, school, and community). In the 2014 CWB report the DAP was used by 16 national offices and five more are currently developing a local language version for measurement in FY15.

structural level strategies to increase access to health care services. Projects reported on using peer education training, formation of peer groups, life skills development training to improve knowledge and attitudes on behaviours and sexual and reproductive health education; to encourage behaviour change in adolescents to prevent unplanned pregnancies, to reduce STI / HIV transmission, and at a community participation level, to encourage uptake of HIV testing and counselling and disseminating messages.

2.6 Use of curriculum to support the adolescent health programming

NOs were asked if there were curriculum to support the adolescent health programming and 12 NOs, 3 ROs and 1 SO indicated that curriculums were available, while 6 NOs indicated that curriculum was not available. For those who had curriculum available, 8 indicated that they developed their own curriculum, 7 used government curriculum, and 2 used USAID or other generic curriculum (see appendices 5.11).

Other ways curricula was sourced or developed was with regional partners (1), developed training guides and manuals to support other training curricula (1), used other NGO curriculum (eg World Relief), or varied ways depending upon the project activity. For example, the NO would develop the project model with the government ministry, then develop a peer education curriculum with NGO and government partner, based on an existing IPPF manual. One SO reported it was still developing a curriculum with partners. Copies of several training guides and curricula for LACR programs were provided.

2.7 Comments from respondents on current adolescent programming experiences

Comments and feedback from NOs from their own adolescent health programming experiences included:

- There have been challenges for some NOs in developing curriculums with unclear guidance on particular approaches to follow. Costs for developing curriculum was mentioned as a barrier and one respondent suggested reusing existing data to redesign curricula using action learning plans and processes.
- Integrated adolescent sexual and reproductive health programming has been fragmented within WV over time with only a few elements of a comprehensive sexual and reproductive health program being implemented by most national offices. In order to adequately address adolescent and sexual reproductive health programming there needs to be a clear mandate on how it will be addressed within WVI to ensure a clear sectoral focus and attention
- A survey of African NOs undertaken by the H&N COP earlier in 2015 found that the WV RH policy was not well understood and identified attitudes and beliefs of some staff as being barriers to including, supporting and implementing ASRH in health and HIV programs

Section 3 - Lessons Learned

3.1 Recommendations from respondents on future adolescent health in WV in the next 5 years

Overall comments from respondents was that WV needs to be doing much more programming in adolescent health, and have tools (project designs, M&E indicators, curriculums, supervision and training to use the tools effectively) available to support national offices to implement adolescent health

programs. Some of the survey questions were difficult for NOs to respond to as WV moves to the future technical approaches which are still evolving.

Table 6 NO recommendations for future adolescent health programming

Focus Area	NO Comments
Programming	• WV should work more on adolescent nutrition, and reproductive health • Prioritize youth friendly spaces for provision of other adolescent health services • Comprehensive care education and more poverty reduction • SRH prevention (including teenage pregnancy, STI, HIV) and addictions (alcohol, drugs), violence advocacy • Continued support to the development of life skills, focusing on key issues such as sexuality, HIV, STDs, addiction and alcoholism, as well as mental health (stress) and drive towards positive health habits • Access to sexual and reproductive health for adolescents with specialised focus on prevention pregnancy, HIV through responsible and sexual and reproductive behaviour • SRH nutrition, disease prevention, protection, career guidance • Increase nutrition and WASH activities • More focus on teenage pregnancy and HIV and AIDS as these cases are rising both in rural and urban settings • Work with both in and out of school children • Develop project models for adolescents which include themes on menstrual hygiene, early marriage, unwanted pregnancies, violence and promote integration of adolescent health into routine service delivery package. • Support abstinence and recognise when this is not possible then adolescents need protection from pregnancy and STIs • Promote protective factors for adolescents that emphasise sexual, reproductive, health, proper nutrient, exercise, addiction prevention and prepare them for a full and productive life
Priorities	• Increase or scale up adolescent health with current interventions with the development of modules for adolescent health • Adolescent health is considered as being left out and there is a lot of catching up • Comprehensive curricula development with appropriate and consistent messaging and engagement • Supporting place based and culturally resonate initiatives that enables youth participation decision making and contribution • Adolescents and youth are a large cohort of populations – it is critical to raise awareness with young people the consequences of early pregnancies and continue work on delaying marriage, family planning and issues around sexual health that have not been addressed in WV • WV should consider direct service delivery as well as providing support services, and consider major causes of adolescent mortality such as road traffic injuries and accidents, as well as drug abuse, as well as prevention of early pregnancies, advocacy to delay marriage, protection of STIs and HIV
Policies	• Focus on advocacy to improve the quality of health services • Addressing adolescent health is critical for addressing MDGs/SDGs
Partnering	• Strengthening networks and partnering in adolescent programming • Need to position ourselves as a credible partner to execute adolescent health programs • Coordinate activities with UNFPA and IPPF where approaches are complementary
Resourcing	• Increase resourcing and capacity building for adolescent development and reproductive health, all NOs should have at least one specialist in adolescent

	programming • More experienced NOs in a particular thematic area should be used to support newer or less experienced NOs in developing their capacity.

3.2 Considerations for planning adolescent programming

Based on staff comments, results of the survey and document review there is an opportunity to reflect on what the information was showing or highlighting;

- NOs have prioritised and invested in adolescent programming, but there is still weak understanding on the impacts that WV has achieved. Shared understanding of adolescent health programming with well-defined terms and concepts is variable in project documentation.
- Highest priority areas to address; high adolescent pregnancy rates, high STI rates, HIV burden, high MMR/maternal morbidity and/or maternal deaths in adolescent age group and high rates of early marriage and violence and substance addiction in specific NO contexts
- Interventions reported being used by NOs most often were health education, comprehensive sex education, youth friendly services, and HIV services. Having appropriate up to date programming tools for these interventions was expressed as a gap by NOs
- Recognition that rural and urban programming for adolescents will be very different and life skills should be well defined for the different health programming contexts, including those who are in school / out of school, HIV positive or negative, married or unmarried, with or without children.
- Some of these priority areas can only be tackled effectively when there is long term overall systemic change which is often beyond the average project period of 3 – 5 years. Consideration for program designs that incorporate advocacy for policy shifts to address social inequities is needed. Pathways of change for adolescents and theoretical underpinning of strategies and interventions should be well described in the project design, with LEAP 3 considerations
- Cultural considerations and action learning processes should be a part of adapting tools and curricula for particular communities for appropriateness and acceptability. Project staff may need support to ensure that their own attitudes and perceptions on adolescence are not barriers for change
- Early evidence from child sponsorship research within WV partnership suggests that projects achieve better outcomes when there are multiple targeted interventions with a selected smaller number of communities rather than few interventions spread out over a large group[26].

3.3 Recommendations for AH strategy development and future programming

1. Adolescent health programming needs a strong leadership within WV health sector to avoid being overly integrated with other approaches, which can result in a loss of clarity with a lack of clear guidance and direction.
2. Recruitment of skilled and capable staff is needed to be able to deliver health programs that improve adolescent sexual and reproductive health outcomes. Project teams responsible for adolescent program implementation should have up to date skills and knowledge on normal healthy adolescent development, and understanding of WV's current SRH policies, knowledge of broader global adolescent best practice programming including WHO recommendations and faith based considerations.

[26] Sharing Phase 2 results from the CSPON Research Project, meeting WVA Burwood 22nd Sep 2015.

3. Given that most of the national offices report their adolescent health programming is in rural context, this is a priority area to address unplanned pregnancies, STIs and HIV prevention urgently. There should be adequate planning to support this as well as emerging priorities, including adolescent health programming in emergencies, drug and alcohol abuse, violence and mental health issues. There is also a need to consider the rapidly growing impact of technology and social media for urban adolescents.
4. Participatory and empowerment approaches for adolescents should be used alongside health focused interventions which increase access to essential health care and other support services.
5. Greater use of existing MOH curricula is needed, as well as SRH content and programming tools which include information that is appropriate for the different age groups of adolescents, and whether in school/out of school, rural or urban context, married or unmarried. HIV positive adolescents have additional health and support needs.
6. The use of the WHO intervention model can be helpful for creating adolescent health programming guidance tools, alongside existing WV programming frameworks and approaches. It will be helpful for NOs to have adolescent health programming frameworks categorised into health system approaches, community interventions and health behaviours frameworks.
7. Sharing programming experiences from more established NOs which have developed tools and materials can effectively support learning and capacity building efforts. Exposure visits can support accelerated programming development and blended learning processes (online and face to face training) should be available to staff for upskilling where national office capacity exists for using it.
8. Where possible NOs should invest in partnering with academic institutions to foster stronger monitoring and evaluation processes and research activities.

3.4 Conclusion

This report provides important evidence of our AH programming in WV and demonstrates the need for an AH strategy and guidance for the partnership. It is clear that many NOs already consider adolescents in their health programming, despite them not being included in the 7-11 H&N strategy. The results of the survey and document review is not exhaustive of all adolescent programming across the WV partnership but does provide an opportunity to understand current and recent programming experiences to help inform future direction.

There is a clear call from national offices to increase the scale and reach of existing adolescent health programming, with strong leadership from the health team to maintain an integrated health focus for greater impact. Adolescents are a rapidly increasing demographic critical to reach with timely interventions for both immediate and long term improved health outcomes. It is a key period in a child's life where navigating through life's challenges will have profound lifelong impact on health.

Early positive achievements with improving adolescent health outcomes by some NOs is clearly evident, while some programming guidance gaps have been identified. These gaps include preventing early pregnancy, poor reproductive health outcomes in adolescents, supporting adolescent pregnant girls and concerns re increasing HIV infections amongst adolescents. There are also emerging issues of violence and substance abuse.

Key approaches must support the development of enabling environments that foster adolescents' ability to thrive, improves healthy lifestyles, supports empowered decision making, and connects adolescents to health services with skilled providers. This requires diverse programming tools and staff competent and upskilled to use and adapt to their national office context. Increased use of monitoring and evaluation tools which can help identify where impact is being achieved will help us build a deeper understanding of what interventions are working well and for whom.

There is a solid justification for increasing organisational capacity and resources, to address current gaps in adolescent health programming. Recommendations for the development of health guidance for NOs includes greater use of existing curriculums, learning from more experienced NOs and rapid updating of staff on existing SRH policies and WHO recommendations. This is needed to effectively prepare for WV's engagement with and contribution to improving adolescent health, especially for girls, in the new Sustainable Development Goals (SDGs) and the new UN Global Strategy for women, children and adolescents.

Finally, cultural considerations for adolescent health with programming guidance remains an important area to address. There may be a need for staff to be supported to ensure they do not remain a barrier for change. Using action learning tools alongside other existing tools will help create a deeper understanding of what success looks like in adolescent health programming, for future programming guidance.

4. Appendices

4.1 Development of the survey questions

The development of the survey questions was closely aligned to the Essential Adolescent Health Interventions in the WHO framework, which groups interventions by mechanism/intervention type on a wide range of health issues that affect adolescents globally. For example interventions can fall into the following groups;

Health System Approaches: Immunisation, Integrated Management of HIV, PMTCT, Contraceptive information and services including SRH/Maternal care/Violence and/Prevention of injury/Mental health

Community Interventions: Promotion of uptake of services, Nutrition, SRH/Maternal care

Health Behaviours: Nutrition, Physical activity, Practicing safe sex, Tobacco control/education, Substance use

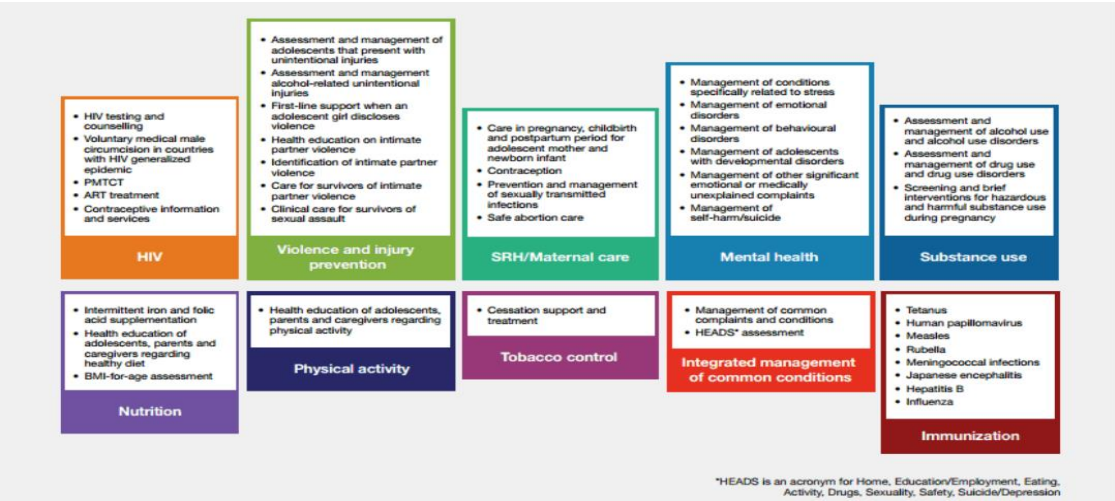

Figure 4. Health services and interventions addressed in WHO guidelines [27]

Survey Monkey Link - The overall results of the survey can be seen at : https://www.surveymonkey.net/results/SM-XX7DBKM2/

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[27] WHO (2014), 'Health for the worlds adolescents- a second chance in the second decade', http://apps.who.int/adolescent/second-decade/section/section_6/level6_1.php

4.2.1 National Office health technical approaches

East Africa	
Ethiopia	Reproductive health as part of HIV prevention
Kenya	Improved Livelihood and Resilience for youth, households and communities for enhanced CWB Improved health status for adolescents by increasing access to reproductive health services;
Uganda	To improve the health and nutrition status of children under 5, adolescents and women of reproductive age by 2020, Reproductive health as part of HIV prevention
South Sudan	Children and their care givers access essential health services
Burundi	Facilitating youth friendly Health Facility Approach and Peer Education in health for adolescents and youth
Middle East/Eastern Europe	
Lebanon & Syria	Health strategic objectives: Children, youth and mothers in Lebanon enjoy improved health and nutrition. Sub objective 1 is WV Lebanon will empower Children, youth and mothers to have improved access to quality basic health care. Sub objective 2: WV Lebanon will support Children, youth and mothers to adopt a healthy lifestyle, with a focus on quality nutrition, sexual and reproductive health and prevention from substance abuse.
Jerusalem West Bank Gaza	Goal: Girls and boys enjoy good health Outcome : improved nutrition and health practices for girls and boys
East Asia	
Mongolia	Improve the health status of children and community
Thailand	Adolescent reproductive health and Teenage pregnancy are addressed
Latin America/Caribbean	
Bolivia	Adolescents develop capabilities and youth as peer educators on sexual reproductive health, HIV and teen pregnancy prevention
Nicaragua	To help strengthen the National and Community Protection System, Health and Education of Children and Adolescents
Honduras	Teen pregnancy prevention, sexual and reproductive health, prevention of disabilities and congenital malformations
Dominican Republic	Contribute to sustainable welfare CAY based on a human rights approach to participation and mobilization of community bases: This objective has three sub-objectives related to adolescence: 2.2. Help empower communities to demand for quality health services to ensure the proper development of children and adolescents. 2. 3. Contribute to the development of knowledge, attitudes and practices that reduce violence against children in the scenes of families, schools, communities and institutions. 2.4. Contribute to local economic development focusing on the implementation of public policies focused on the economic rights of young people.
Peru	In the approach of teenagers it has integrated sexual reproductive health training program
South Asia & Pacific	
Philippines	Reduce vulnerabilities of children to undernutrition, TB, HIV and AIDS
West Africa	
Southern Africa	
Swaziland	Focus on young women and girls: Given the gender bias of the epidemic deliberate efforts will be made to target women and young girls. This is one of the principles guiding principles and data in Swaziland generally indicate HIV prevalence is higher among adolescents and as such adolescents are a priority target for interventions. One of the strategic outcomes include reducing HIV incidence amongst children and youth. This is also alluded to in the context data that informed the strategy

4.2.2 Brief details of National Office strategies which include adolescents

East Africa	
Ethiopia	Life skills, economic development, reproductive health
Kenya	Education, Life skills Economic development. Strategy FY16 -20; , Improved protection, access and quality education for adolescents; Improved health status for adolescents by increasing access to reproductive health services; Adolescents prepared for economic opportunities,
Uganda	Education, life skills, livelihoods and health
South Sudan	Health sector in South Sudan is already targeting adolescents through it primary health care services and will be specifically targeting the adolescents in the COH rollout
Rwanda	WV Rwanda strategy includes adolescents mainly in education
Burundi	Vocational training and life skills promotion for adolescents, in collaboration with food security for economic empowerment & ECCD & Education with infrastructure development, quality improvement, community development

Middle East/Eastern Europe	
Lebanon & Syria	Education and Life skills, Health, Child protection sectors include adolescents. Our current strategy date is rom 2014-2016
Jerusalem West Bank Gaza	For the education it's part of leadership program and extra curricula activities , for the ED it's part of the sky clubs .Our strategy dates are FY13-FY18
East Asia	
Cambodia	Child Protection, Education
Mongolia	Youth life skills in Health, education and economic
Thailand	Improve the health condition of women children and the most vulnerable population: Health Department
Latin America/Caribbean	
unnamed	Advocacy and implementation of skills for life 2013 strategy
Bolivia	Strategy 20112015 are the following areas: sexual and reproductive health, life skills, advocacy, protection, gender, education,
Mexico	Life skills, sexual health, active citizenship
Nicaragua	Education and life skills, protection, health, HIV
Honduras	It includes life skills in sexual and reproductive health and education, economic development, protection, domestic violence, teen pregnancy prevention
Dominican Republic	The 2013 -2015 national strategy of intervention was defined in the National Office by age groups 0-5, 6-12 and 13-21 years for the 12-21 group Voice Project. It develops action that includes citizenship, prevention of social risks and life skills, education and economic development.
Peru	Parenting with tenderness, entrepreneurship and participation
South Asia & Pacific	
unnamed	Health, Nutrition and WASH
Philippines	Health- HIV and AIDS, Education- Life Skills, Econ Dev, DRR
West Africa	
Senegal	Education; Food security; child protection
Southern Africa	
Swaziland	Education, life skills and health. 2015
South Africa	Education, child protection & economic development
Other – Australia Program	Culturally centred positive youth development, life skills. Dates of strategy- 2015-2017

4.2.3 National Office description of health interventions

East Africa	
Ethiopia	-
Kenya	We have trained health workers in Youth friendly services and established Youth friendly centres where youth receive SRH information and services as well as counselling
Uganda	Interventions target HIV youth peer groups and others for reproductive age group that starts from age 15. They need commodities.
Burundi	-
Middle East/Eastern Europe	
Lebanon & Syria	Health education: the project targeted adolescent and youth's health, to prevent them from adopting risky behaviours and promoting healthy lifestyles, having a focus on substance use issues and sexual and reproductive health. In this scope, World Vision created a National Youth program on Adolescent Health in partnership with Lebanese Red Ross youth Department and youth were provided with capacity building opportunities to improve their knowledge and skills on YAH and disseminate information.
Jerusalem West Bank Gaza	we implement activities related to sexual and reproductive health at schools part on health committee model and at friendly spaces in Gaza
East Asia	
Mongolia	Just HIV/AIDS and handwashing awareness raising activities have been done in some ADPs
Latin America/Caribbean	
Unnamed country	With Health First campaign it has boosted sexual education access here but still need much more

Bolivia	Young people are oriented on the issues of prevention of teenage pregnancy and SSR and after completing a training process will act as multipliers of information, which spread their acquired knowledge with easy to understand language and non-academic other teenagers inside and outside Classroom avoiding any loss of opportunity. To ensure that knowledge is disseminated properly, skills development activities and life skills such as painting, theatre and music where teenagers sensitized prevention messages and provide their correct knowledge are made. It seeks to improve the level of awareness and information involving Educators adolescent peer regarding the care of the SSR, pregnancy prevention and additional care in the family and in the community for pregnant teenagers by developing preventive behaviours and seeking timely care and teens connect with the public health system as a legal approach Primary Health Care
Mexico	WV Mexico uses a holistic approach, our intervention from a model where life skills while young people are encouraged to learn and use them to make decisions regarding their sexual health, drug abuse and alcoholism
Nicaragua	The country lacks sexual and reproductive health including psychological care of adolescents who become pregnant
Honduras	Most of the interventions are made in coordination with the Ministry of Health in the program of care for families and teens, as World Vision, in the past five years developing the campaign Child Health where they addressed all issues mentioned above in areas where WVH has their actions, also has support in the development of policy sexual and reproductive health will boost the government and supported the installation of a telephone line for emergencies or problems of adolescents abuse crisis or any other situation that requires counselling,
Dominion Republic	The procedures performed are aimed at: Sexual Reproductive Health, Teenage Pregnancy Prevention, Life Skills (prevention of Sexually Transmitted Infections and HIV / AIDS) pairs using the strategies and playing your door.
Peru	Preventive work to decrease teen pregnancy in the context of reproductive sex education in secondary schools
South Asia & Pacific	
Unnamed country	Health Education for adolescent girls at school, TT immunization and advice for iron supplementation from GoB outlets and advice regarding food habits.
Sri Lanka	Adolescent health promotion awareness using school health programmes, SRH programmes
India	-
Philippines	Health education are done mostly in communities and in schools. Topics usually include values education, harmful substances: smoking, drinking, drugs, and positive relationships with peers and family, HIV and AIDS.
West Africa	
Southern Africa	
Swaziland	CSE is the main thrust of interventions targeting teenagers
Other - WV US (Global)	Youth friendly SRH services are included in 2 grants in Kenya but there are many barriers to access - attitudes , stigma around ASRH

4.2.4 National Office comments on adolescent health sensitive interventions

East Africa	
Ethiopia	Through education, WASH, Livelihood and Child Protection sections had adolescent sensitive interventions integrated into their routine development activities
Kenya	22% of adolescents in our ADP confirmed that their parents do not have time to talk or listen to their issues. This led the girls and boys to seek advice from media and peers, some of which led to negative influence and resulted in engaging in vices such as drugs and substance abuse.
Rwanda	Girls' retention strategy should be a focus in quality of education including school feeding programs and menstruation services at school. ADRH clubs are key to give space to adolescents to ask questions regarding their body changes.
Middle East/Eastern Europe	
Jerusalem West Bank Gaza	As mentioned all are part of the school health model that we implement
East Asia	
Latin America/Caribbean	
Mexico	According to information obtained through the DAP, adolescents and young people have no recreational areas in their communities. WV Mexico promotes the organisation of tournaments as a way to deal with this problem, while the capacities of young people is developed to organise on topics of interest.
Nicaragua	A large percentage of adolescent young mothers' girls do not know how to manage their new roles when entering the labour market for obtaining income profit for the subsistence of the new family. There are young adolescents of poor economic status who leave school to enter the market employment but do so without tools that enable them to compete.
Honduras	These issues are part of the approach to child protection and guidance given from schools and families, and it is something that is included in the new action plans WVH

Dominican Republic	Level work in schools with behavioural changes and sanitation. Readjustment of spaces for education and recreation. Training and empowerment of young people to decision making and self-care measures and rights based protection.
Peru	It has a capacity building work proactively to decrease teen pregnancy complemented with entrepreneurship skills
South Asia & Pacific	
Unnamed country	Through community facilitators at household level and through school program
Philippines	Adolescents in school and out of school have taken part in various interventions like education- life skills, livelihood, wash, etc.
West Africa	
Southern Africa	
Swaziland	The country has realised and moved forward in CSE but is yet to acknowledge protection from violence though there is high reporting of such cases

4.2.5 National Office comments on policy and advocacy interventions

East Africa	
Ethiopia	WVE is member of several adolescent health related national TWGs, In line with the national legal setup of no marriage before age 18, WVE routinely support activities at AP level on early marriage awareness and monitoring and prevention of early marriage. As part of capacity building to health sector responses SRH services have been strengthened
Kenya	WVK is working with the National Division of reproductive Health to develop adolescent friendly health policies; Supporting birth registration in partnership with the Department of Civil Registration; Working with other partners to advocate for RH etc
Middle East/Eastern Europe	
East Asia	
Thailand	Coordinate and join the network
Latin America/Caribbean	
Bolivia	It works with the methodology CVA (voice of citizen action) for the accreditation of health services, educational support units in the areas of school curricula, educational quality, production of teaching materials, agreements to improve access to health services.
Mexico	World Vision Mexico through its area of Advocacy and with other civil society has promoted the creation of the General Law on Children and Adolescents.
Nicaragua	It has contributed to strengthening local capacities of the Ministry of Health and local actors allowing better access to health services but still need to be done
Honduras	It works in child protection based on the law and policy making sexual and reproductive health as well as in national plans adolescent care and education.
Dominican Republic	It has made partnership with Ministries of Health for taking anthropometric measurements. Working in coordination with the Ministry of Interior and Police for the prevention of use of drugs and controlled substances. Purchase of educational materials to enable Libraries and Biological.
Peru	It has participated in regular coordination with basic education and secondary working is providing schools with the Module healthy lifestyles for teenagers
South Asia & Pacific	
Philippines	Global Week of Action is one advocacy intervention where children and youth voices are heard by the local leaders/ legislators in the communities.
West Africa	
Southern Africa	
Swaziland	Age and sex are important issues in increasing access to services particularly SRH services for adolescents

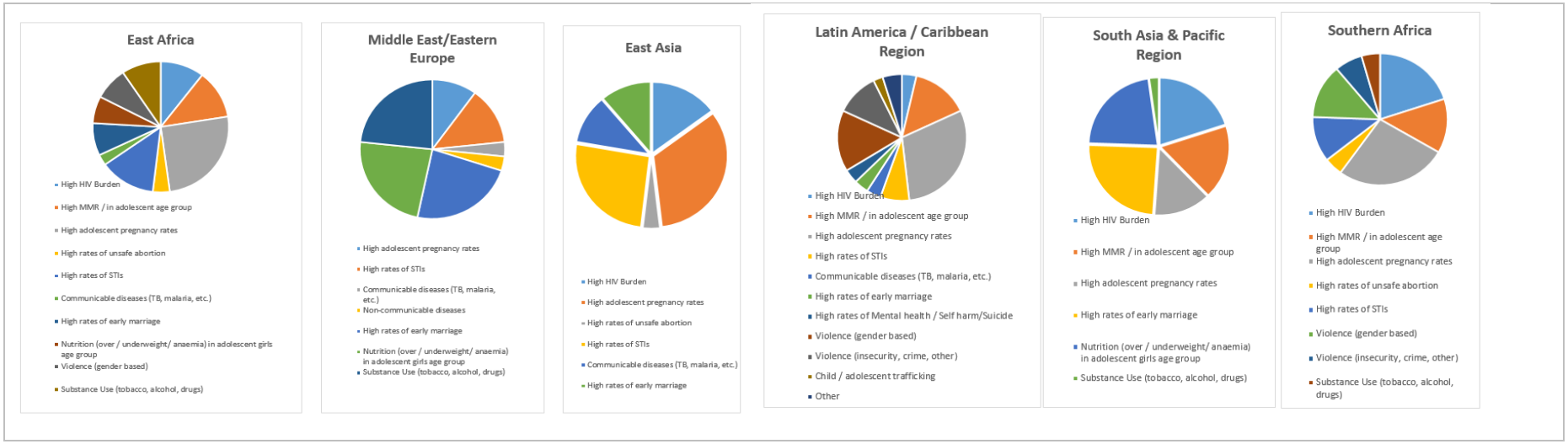
4.3.1 Areas which are relevant for NO or sub-national context in regard to adolescent programming *(Number 1 – 5 refers to ranking placement by NO)*[28]*. 1 = highest priority, 2 = next highest, etc*

Response	High HIV Burden	High MMR / in adolescent age group	High adolescent pregnancy rates	High rates of unsafe abortion	High rates of STIs	Communicable diseases (TB, malaria, etc.)	Non-communicable diseases	High rates of early marriage	underweight/ anaemia) in adolescent girls age group	Mental health / Self harm/Suicide	Violence (gender based)	Violence (insecurity, crime, other)	Fragile context	Child / adolescent trafficking	Substance Use (tobacco, alcohol, drugs)	Other
East Africa																
Ethiopia		2			5	4		3	1							
Kenya	5		2					3			4				1	
Uganda	3	2	1	5	4											
Rwanda	5		1		3						2				4	
Sudan																
Burundi	3	5	1	4	2											
Middle East/Eastern Europe																
Lebanon & Syria					2	5		3	4						1	
Jerusalem West Bank Gaza			3				5	2	1						4	
East Asia																
Mongolia			2		1	3										
Thailand	2		1	5	4			3								
Latin America / Caribbean Region																
Unnamed country	5		1								3			4		2
Bolivia		2	1		5	3					4					
Mexico			3					4			5	1				
Honduras	4	3	1		2			5								
Dominion Republic		1	4		5						3	2				
Peru			1							3	2					
South Asia & Pacific Region																
Unnamed country	4	1	5					2	3							

[28] Several respondents listed less than 5 priorities for adolescent programming.

India	4	3	5					2	1								
Philippines	1		2					3	4							5	
West Africa																	
Southern Africa																	
Lesotho	2	1	3	4	5												
Swaziland	1	5	2		3						4						
South Africa			1		5						2	3				4	
Other - Australia Program		2	3	4	5												1

4.3.2 Adolescent programming context by regions using pie charts based on combined rankings (Note; West Africa is not included, and pie charts are illustrative representations only of NOs listed in 4.3.1, and it not an exhaustive list of all contexts)



4.4.1 National Office types of adolescent health interventions

Respondents	Health education	Comprehensive sexuality education	Youth friendly health services	HIV services for adolescents	Youth friendly SRH services	Immunisation – (HPV, TT, Rubella, HEP B, measles	Psychosocial support (mental health, counselling, treatment and	Nutritional supplementation (iron folate for adolescent	Not implementing adolescent health interventions	Other (please specify)

							care)	girls or other nutrition support)		
East Africa										
Ethiopia	✓		✓	✓	✓			✓		
Kenya	✓	✓	✓	✓	✓		✓	✓		
Uganda	✓	✓	✓	✓	✓					
Burundi	✓	✓	✓	✓	✓					
Middle East/Eastern Europe										
Lebanon & Syria	✓	✓	✓		✓					
Jerusalem West Bank Gaza	✓						✓			✓
East Asia										
Mongolia	✓									
Latin America/Caribbean										
Unnamed country		✓	✓		✓					
Bolivia	✓	✓								
Mexico	✓									✓
Nicaragua		✓	✓	✓	✓		✓			
Honduras	✓	✓	✓	✓		✓	✓	✓		
Dominion Republic	✓	✓								
Peru		✓								
South Asia & Pacific										
Unnamed country	✓		✓			✓		✓		
Sri Lanka	✓	✓					✓			
India	✓							✓		
Philippines	✓									
West Africa										
Southern Africa										
Swaziland	✓	✓	✓	✓	✓					
Other - WV US (Global)	✓				✓					

4.4.2 National Office comments on adolescent health interventions

East Africa	
Ethiopia	-
Kenya	We have trained health workers in youth friendly services and established youth friendly centres where youth receive SRH information and services as well as counselling
Uganda	Interventions target HIV youth peer groups and others for reproductive age group that starts from age 15. They need commodities.
Burundi	-
Middle East/Eastern Europe	
Lebanon & Syria	Health education: the project targeted adolescent and youth's health, to prevent them from adopting risky behaviours and promoting healthy lifestyles, having a focus on substance use issues and sexual and reproductive health. In this scope, World Vision created a National Youth program on Adolescent Health in partnership with Lebanese Red Ross youth Department and youth were provided with capacity building opportunities to improve their knowledge and skills on YAH and disseminate information.
Jerusalem West Bank Gaza	We implement activities related to sexual and reproductive health at schools part on health committee model and at friendly spaces in Gaza
East Asia	

Mongolia	Just HIV/AIDS and handwashing awareness raising activities have been done in some ADPs
Latin America/Caribbean	
Unnamed country	With Infant Health First campaign it has boosted sexual education access here but still need much more needed
Bolivia	Young people are oriented on the issues of prevention of teenage pregnancy and SSR and after completing a training process will act as multipliers of information, which spread their acquired knowledge with easy to understand language and non-academic other teenagers inside and outside Classroom avoiding any loss of opportunity. To ensure that knowledge is disseminated properly, skills development activities and life skills such as painting, theatre and music where teenagers sensitized prevention messages and provide their correct knowledge are made. It seeks to improve the level of awareness and information involving Educators adolescent peer regarding the care of the SSR, pregnancy prevention and additional care in the family and in the community for pregnant teenagers by developing preventive behaviours and seeking timely care and teens connect with the public health system as a legal approach Primary Health Care
Mexico	WV Mexico uses a holistic approach, our intervention from a model where life skills while young people are encouraged to learn and use them to make decisions regarding their sexual health, drug abuse and alcoholism
Nicaragua	The country lacks sexual and reproductive health including psychological care of adolescents who become pregnant
Honduras	Most of the interventions are made in coordination with the Ministry of Health in the program of care for families and teens, as World Vision, in the past five years developing the campaign Child Health where they addressed all issues mentioned above in areas where WVH has their actions, also has support in the development of policy sexual and reproductive health will boost the government and supported the installation of a telephone line for emergencies or problems of adolescents abuse crisis or any other situation that requires counselling,
Dominion Republic	The procedures performed are aimed at: Sexual Reproductive Health, Teenage Pregnancy Prevention, Life Skills (prevention of Sexually Transmitted Infections and HIV / AIDS) pairs using the strategies and playing your door.
Peru	Preventive work to decrease teen pregnancy in the context of reproductive sex education in secondary schools
South Asia & Pacific	
Unnamed country	Health Education for adolescent girls at school, TT immunization and advice for iron supplementation from GoB outlets and advice regarding food habits.
Sri Lanka	Adolescent health promotion awareness using school health programmes, SRH programmes
India	-
Philippines	Health education are done mostly in communities and in schools. Topics usually include values education, harmful substances: smoking, drinking, drugs, and positive relationships with peers and family, HIV and AIDS.
West Africa	
Southern Africa	
Swaziland	CSE is the main thrust of interventions targeting teenagers
Other - WV US (Global)	Youth friendly SRH services are included in 2 grants in Kenya but there are many barriers to access - attitudes , stigma around ASRH

4.5.1 National Office types of adolescent health sensitive interventions

	Quality education and schooling through secondary level	WASH specifically targeting adolescents (safe water and sanitation at school and home	Menstrual Hygiene	Opportunities for physical activity	Eliminating or preventing child marriage	Training in parenting skills	Opportunities for early decision making	Protection from violence and judicial/legal support	Ensuring visibility through enhanced data collection on adolescents	Training on Livelihoods and economic development skills	Child Protection or child safety	Not Implementing adolescent health sensitive interventions	Other (please specify)
East Africa													
Ethiopia	✓	✓	✓		✓	✓				✓	✓		
Kenya	✓	✓	✓		✓	✓	✓	✓		✓	✓		
Uganda	✓		✓		✓		✓	✓		✓			

Burundi			✓		✓	✓		✓		✓	✓		
Rwanda						✓	✓	✓	✓	✓			
Middle East/Eastern Europe													
Lebonon & Syria		✓	✓	✓							✓		
Jerusalem West Bank Gaza		✓		✓									
East Asia													
Mongolia													
Latin America/Caribbean													
Unnamed country	✓						✓	✓	✓				
Bolivia	✓	✓		✓			✓	✓		✓	✓		
Mexico				✓			✓						
Nicaragua										✓			
Honduras	✓	✓					✓	✓					
Dominion Republic		✓		✓			✓	✓		✓	✓		
Peru	✓									✓			
South Asia & Pacific													
Unnamed country	✓	✓									✓		
Sri Lanka	✓					✓	✓	✓		✓			
India	✓				✓		✓			✓			
Philippines	✓	✓		✓			✓			✓	✓		
West Africa													
Southern Africa													
Swaziland			✓		✓	✓		✓					
Other - WV US (Global)													

4.5.2 National office comments on adolescent health sensitive interventions

East Africa	
Ethiopia	Through education, WASH, Livelihood and Child Protection sections had adolescent sensitive interventions integrated into their routine development activities
Kenya	22% of adolescents in our ADP confirmed that their parents do not have time to talk or listen to their issues. This led the girls and boys to seek advice from media and peers, some of which led to negative influence and resulted in engaging in vices such as drugs and substance abuse.
Rwanda	Girls' retention strategy should be a focus in quality of education including school feeding programs and menstruation services at school. ADRH clubs are key to give space to adolescents to ask questions regarding their body changes.
Middle East/Eastern Europe	
Jerusalem West Bank Gaza	As mentioned all are part of the school health model that we implement
East Asia	
Latin America/Caribbean	
Mexico	According to information obtained through the DAP, adolescents and young people have no recreational areas in their communities. WV Mexico promotes the organisation of tournaments as a way to deal with this problem, while the capacities of young people is developed to organise on topics of interest.
Nicaragua	A large percentage of adolescent young mothers' girls do not know how to manage their new roles when entering the labour market for obtaining income profit for the subsistence of the new family. There are young adolescents of poor economic status who leave school to enter the market employment but do so without tools that enable

	them to compete.
Honduras	These issues are part of the approach to child protection and guidance given from schools and families, and it is something that is included in the new action plans WVH
Dominican Republic	Level work in schools with behavioural changes and sanitation. Readjustment of spaces for education and recreation. Training and empowerment of young people to decision making and self-care measures and rights based protection.
Peru	It has a capacity building work proactively to decrease teen pregnancy complemented with entrepreneurship skills
South Asia & Pacific	
Unnamed country	Through community facilitators at household level and through school program
Philippines	Adolescents in school and out of school have taken part in various interventions like education- life skills, livelihood, wash, etc
West Africa	
Southern Africa	
Swaziland	The country has realised and moved forward in CSE but is yet to acknowledge protection from violence though there is high reporting of such cases

4.6.1 National office types of policy and advocacy interventions

	Working with government ministries – technical or advisory working groups	Policy or Legal Change eg to facilitate healthy behaviours around drug & alcohol, tobacco, food and other issues	Campaign eg Eliminate child marriage /universal minimum age of marriage at 18 years	Birth and marriage registration	Access to quality, private, confidential SRH services	Access to other critical services regardless of age, gender, marital or other status	Supporting schools with curriculum or production of materials, etc	Strengthening collection and use of data for policy formulation and program delivery	Creating opportunities for children's voices to be heard to inform policy	Not implementing policy or advocacy interventions	Other (please specify)
East Africa											
Ethiopia	✓		✓	✓	✓						
Kenya	✓	✓	✓	✓	✓	✓	✓	✓	✓		
Uganda				✓	✓	✓	✓		✓		
Rwanda	✓	✓	✓	✓	✓		✓		✓		
Burundi			✓	✓	✓						
Middle East/Eastern Europe											
Lebanon & Syria										✓	
Jerusalem West Bank Gaza										✓	
East Asia											
Thailand									✓		
Latin America/Caribbean											
Unnamed country					✓	✓	✓	✓			
Bolivia					✓		✓		✓		
Mexico									✓		✓
Nicaragua					✓						
Honduras				✓	✓			✓			
Dominican Republic				✓			✓	✓	✓		
Peru							✓				
South Asia & Pacific											

Unnamed country	✓			✓							
Sri Lanka	✓			✓							
India			✓			✓	✓		✓		
Philippines				✓		✓	✓	✓	✓		
West Africa											
Southern Africa											
Swaziland				✓	✓	✓		✓	✓		

4.6.2 National Office comments on policy and advocacy interventions

East Africa	
Ethiopia	WVE is member of several adolescent health related national TWGs, In line with the national legal setup of no marriage before age 18, WVE routinely support activities at AP level on early marriage awareness and monitoring and prevention of early marriage. As part of capacity building to health sector responses SRH services have been strengthened
Kenya	WVK is working with the National Division of reproductive Health to develop adolescent friendly health policies; Supporting birth registration in partnership with the Department of Civil Registration; Working with other partners to advocate for RH etc
Middle East/Eastern Europe	
East Asia	
Thailand	Coordinate and join the network
Latin America/Caribbean	
Bolivia	It works with the methodology CVA (voice of citizen action) for the accreditation of health services, educational support units in the areas of school curricula, educational quality, production of teaching materials, agreements to improve access to health services.
Mexico	World Vision Mexico through its area of Advocacy and with other civil society has promoted the creation of the General Law on Children and Adolescents.
Nicaragua	It has contributed to strengthening local capacities of the Ministry of Health and local actors allowing better access to health services but still need to be done
Honduras	It works in child protection based on the law and policy making sexual and reproductive health as well as in national plans adolescent care and education.
Dominican Republic	It has made partnership with Ministries of Health for taking anthropometric measurements. Working in coordination with the Ministry of Interior and Police for the prevention of use of drugs and controlled substances. Purchase of educational materials to enable Libraries and Biological.
Peru	It has participated in regular coordination with basic education and secondary working is providing schools with the Module healthy lifestyles for teenagers
South Asia & Pacific	
Philippines	Global Week of Action is one advocacy intervention where children and youth voices are heard by the local leaders/ legislators in the communities.
West Africa	
Southern Africa	
Swaziland	Age and sex are important issues in increasing access to services particularly SRH services for adolescents

4.7 National Office responses of who was delivering the policy and advocacy interventions

	WV – direct delivery without partner	WV – through partners	NGO partners	Ministry of Health	Ministry of Education	Other Ministry	Private sector	Civil Society Organisations	Researchers	Not Applicable	Other (please specify)
East Africa											
Ethiopia	✓	✓	✓	✓	✓	✓		✓			
Kenya		✓				✓					
Uganda		✓	✓	✓							
Rwanda				✓		✓					✓
Burundi		✓		✓	✓	✓					

Middle East/Eastern Europe											
Lebanon & Syria		✓	✓						✓		
Jerusalem West Bank Gaza	✓	✓		✓	✓			✓			
East Asia											
Thailand											
Latin America/Caribbean											
Unnamed country		✓	✓	✓	✓			✓			
Bolivia	✓			✓				✓			
Mexico		✓									
Nicaragua		✓		✓							
Honduras		✓		✓	✓			✓			
Dominican Republic		✓		✓	✓			✓			
Peru		✓									
South Asia & Pacific											
Unnamed country	✓	✓	✓	✓							
Sri Lanka	✓	✓		✓	✓	✓		✓			
India	✓		✓	✓			✓	✓	✓		
Philippines	✓	✓	✓	✓	✓	✓	✓	✓			
West Africa											
Southern Africa											
Swaziland	✓	✓		✓	✓						

4.8 Places where interventions were occurring and who were they being implemented in partnership with

Place of Intervention;								In partnership with;						
	Youth friendly centres	Health facilities	Mobile Clinics	Community centres	Online / Mhealth	Not Applicable	Other (please specify)	Adolescents	Parents	School teachers	Community leaders	Faith leaders	Not Applicable	Other (please specify)
East Africa														
Ethiopia														
Kenya														
Uganda														
Rwanda														
Burundi														
Middle East/Eastern Europe														
Lebanon & Syria														
Jerusalem West Bank														

Gaza														
East Asia														
Thailand														
Latin America/Caribbean														
Unnamed country														
Bolivia														
Mexico														
Nicaragua														
Honduras														
Dominican Republic														
Peru														
South Asia & Pacific														
Unnamed country														
Sri Lanka														
India														
Philippines														
West Africa														
Southern Africa														
Swaziland														

Other:
Nicaragua – In communities with the Ministry of Health
Dominican Republic – Not listed
Peru – Schools
Latin American Region – youth clubs and call centre
Mexico – Secondary Schools
Jerusalem West Bank Gaza – schools
Lebanon & Syria – Lebanese Red Cross Centres
Rwanda – In schools

Other:
Honduras – Government technicians
Uganda – Community Health Workers

4.9.1. National Office cadre of staff delivering the program

	Trained Health workers	Community health workers	Peers	Volunteers	Youth pastors	WV – development facilitator	WV – project officer	Not Applicable	Other (please specify)
East Africa									
Ethiopia	✓	✓	✓	✓		✓	✓		
Kenya	✓	✓		✓			✓		
Uganda	✓	✓	✓			✓	✓		
Rwanda	✓		✓	✓	✓	✓	✓		✓
Burundi	✓	✓	✓	✓		✓			
Middle East/Eastern Europe									
Lebanon & Syria			✓	✓			✓		
Jerusalem West Bank Gaza			✓	✓		✓	✓		✓
East Asia									

Thailand									
Latin America/Caribbean									
Unnamed country	✓			✓	✓	✓	✓		
Bolivia		✓	✓			✓	✓		
Mexico			✓	✓		✓	✓		✓
Nicaragua			✓			✓			
Honduras	✓	✓	✓	✓	✓	✓	✓		
Dominican Republic	✓	✓	✓	✓	✓	✓	✓		
Peru			✓			✓			
South Asia & Pacific									
Unnamed country	✓	✓				✓	✓		
Sri Lanka	✓	✓				✓			
India	✓	✓	✓	✓		✓	✓		
Philippines	✓	✓	✓	✓		✓	✓		
West Africa									
Southern Africa									
Swaziland	✓	✓	✓	✓	✓	✓	✓		
Other *Mexico – Peer educators* *Jerusalem West Bank Gaza – MOE – MOH staff* *Rwanda – Trained school teachers (both male and female)*									

4.9.2 National Office setting of adolescent health programming

	Rural	Urban	National	Fragile Context	Not Applicable	Other (please specify)
East Africa						
Ethiopia	✓	✓	✓			
Kenya	✓					
Uganda	✓	✓				
South Sudan						
Rwanda	✓					✓
Burundi	✓					
Middle East/Eastern Europe						
Lebanon & Syria	✓	✓	✓			
Jerusalem West Bank Gaza	✓			✓		
East Asia						
Thailand						
Latin America/Caribbean						
Bolivia	✓	✓	✓			
Mexico			✓			
Nicaragua	✓					
Honduras	✓	✓	✓			

Ecuador	✓					
Dominican Republic	✓			✓		✓
Peru	✓	✓				
South Asia & Pacific						
Unnamed country	✓	✓				
Sri Lanka						
India	✓	✓				
Philippines	✓	✓	✓			
West Africa						
Senegal						
Southern Africa						
Swaziland	✓		✓			
South Africa						

4.10 National Office details of projects & funding

East Africa		**ADP**	**Grant**	**Not Applicable**	**Other**
Ethiopia	E-FACE, Preventive Care Package; Sponsorship Projects	✓	✓		
Kenya	Included in attachment of project details.		✓		
Uganda		✓	✓		
Rwanda	it was HIV& AIDS programing having life skills among key components	✓			✓
Burundi	RAMBA Project, B201527		✓		
Middle East/Eastern Europe					
Lebanon & Syria	Youth and adolescent health project, Project number: L199437				✓
Jerusalem West Bank Gaza	school health committees	✓			
East Asia					
Thailand					
Latin America/Caribbean					
Unnamed country	First Infant health campaign H196850		✓		
Bolivia	Rangers Youth Health "light chains"	✓	✓		
Mexico	All PDAs in Mexico have a project to address the group of 13-18 years	✓			
Honduras		✓	✓		✓
Ecuador	Sexual and Reproductive Health HIV Aids and STI prevention	✓			
Dominican Republic	Voice and Action and Education for Life.	✓			
Nicaragua		✓			✓
Peru		✓			
LACRO	Models of Learning SRH education and life skills to Prevent HIV				
South Asia & Pacific					
Unnamed country	World Vision Nutrition Initiative Project – Nobokoli	✓	✓		✓
India	Integrated Programming for Child health (IPCH) in WV India	✓			
Philippines		✓			
West Africa					

Southern Africa					
Swaziland	Hong Kong HIV prevention project		✓		
Other					
WV Germany	Improved maternal and child health in Armenia. the goal of the project is improved reproductive health of boys, girls and women of reproductive age and improved health care of young children		✓		
MEER	SRH projects/components in Armenia, Lebanon, Bosnia and Herzegovina, Afghanistan,		✓		
LACRO	Models of Learning SRH education and life skills to Prevent HIV				✓
SARO				✓	
Other responses: Nicaragua – not listed, Ecuador – not listed, LACRO – not listed Lebanon & Syria – Supported by the Australian Government, DFAT South Asia and Pacific Region – PNS, Rwanda – Funds from different SOs; US, Canada, Australia					

4.10 National Office evidence of results of programming

	Have you collected any evidence of the results of the adolescent programming?	Have you presented or published any of this information to audiences?	Can you provide us with links to these documents or publications?
East Africa			
Ethiopia	No	No	N/A
Kenya	Yes	No	Will send attachment of project details.
Uganda	No	No	No
Rwanda	Yes	Yes	It is not a baseline but it is a WVI online reporting system called CHARMS. I think it is still working, but it capture indicators on HIV and life skills mainly.
Burundi	Yes	Yes	Yes - already provided to the regional advisor
Middle East/Eastern Europe			
Lebanon & Syria	Yes	No	N/A
Jerusalem West Bank Gaza	No	No	N/A
East Asia			
Latin America/Caribbean			
Bolivia	Yes	No	Yes
Mexico	No	N/A	Right now we are doing a systematization of experience, which we share with the regional advisor at the end of AF15
Nicaragua	Yes	Yes	I still have not been provided with the report as the project is being evaluated
Honduras	No	No	-
Ecuador	No	No	-
Dominican Republic	Yes	No	No
Peru	Yes	Yes	Yes – already provided to regional advisor
South Asia & Pacific			
Unnamed country	Yes	Yes	So far the evidence we have is very early information on the program's intervention that can be found in the IPCH Mid Term Review Report. But hopefully we will have more evidence after IPCH Final Evaluation

			in Oct 2015.
India	Yes	No	Yes
Philippines	No	No	During 2013 baseline, Development Asset Survey (DAP) was used as a baseline tool for youth 12-18 years old (although this is not specific to health).
West Africa			
Southern Africa			
Swaziland	No	No	-
SARO	No	No	No
MEER	Yes	Yes	Couple baselines, evaluation reports, etc are on local languages
LACRO	Yes	No	
WV Germany	Yes	N/A	Evaluation will take place Sep-Nov 2015

4.11 National Office curriculum to support the adolescent programming

Were there any curriculum to support the adolescent health programming?		*If yes indicate type used;*			
		Developed own curriculum	Used government curriculum	Other ie: USAID or other gric curriculum	Other
East Africa					
Ethiopia	No				
Kenya	Yes		✓		
Uganda	Yes		✓	✓	
Rwanda	Yes				There were curriculum which were developed from the region. They were called "life skills curriculum".
Burundi	No				
Middle East/Eastern Europe					
Lebanon & Syria	Yes				Developed Training guides and manuals (TOT) on Drug use and sexual and reproductive health
Jerusalem West Bank Gaza	No		✓		
East Asia					
Latin America/Caribbean					
Bolivia	Yes	✓			
Mexico	Yes	✓			
Nicaragua	Yes		✓		
Honduras	Yes		✓		
Ecuador	No				
Dominican Republic	No				
Peru	Yes	✓			Module Healthy Lifestyles in adolescents
South Asia & Pacific					
Unnamed country	Yes	✓	✓		
India	Yes	✓			
Philippines	No				

West Africa					
Southern Africa					
Swaziland	Yes	✓			
SARO	Yes			✓	Choose Life peer education training module by World Relief
MEER	Yes				Depend on NOs' relationships with authorities (education and health), In BiH for Roma SRH WV BiH developed model with Roma and Government authorities, for peer education model was developed with NGO partner, government authorities based on IPPF manual, etc.
LACRO	Yes	✓	✓		
WV Germany	N/A				
Australia Program	Yes	✓			Currently developing, can share once developed

4.12 Respondents' comments on where should WV adolescent health be headed in the next 5 years

		Would you be interested or willing to test any tools or resources which might be developed?
East Africa		
Ethiopia	Should work more on adolescent nutrition, and reproductive health	Yes
Kenya	-	-
Uganda	Prioritize youth friendly spaces for provision of other adolescent health services	Yes
Rwanda	GC should provide clear guidance to RO and NO to integrate ADRH in NO strategies. Resource mobilisation on ADRH is key address issues. ADRH indicators should be part of every health or livelihood related baseline, mid-year review or end of project evaluation and learning documented for future programming. Conference and w/shops organized at different levels. ADRH can also be a cross cutting issue. Because ADRH is something which has been talked enough, almost forgotten, all NOs should have at least one specialist at NO to ensure the sector is given its value for tangible results	Yes
Burundi	WV adolescent Health should be going in the next 5 years because there is still a lot to do, adolescent health is considered as left out here and we have to catch up!	Yes
East Africa Regional Office	-	Yes
Middle East/Eastern Europe		
Lebanon & Syria	This project was supposed to end in September 2016, but there was a cut in the fund from the Australian government so the project ended in June 2015 and the evaluation will be conducted during august and September 2015.	No
Jerusalem West Bank Gaza	It's very important to focus on such interventions,. It was included as part of our technical approach and we do hope that we will be able to test the effectiveness of the model in FY16	Yes
East Asia		
Cambodia	In Cambodia there is a very large cohort of adolescents and youth; nearly 60% of the population is made up of young people. It would be an opportunity missed if adolescent health was not addressed. It would be critical to raise awareness of the young people in areas of early pregnancies and it's de-merits, delaying age of marriage, family planning and issues around sexual health which have never been addressed in WV.	Yes
Thailand	strengthening network and partnering with government and other CSO/NGOs	Yes
Latin America/Caribbean		

Unnamed country	Comprehensive care education more poverty reduction	Yes
Bolivia	SRH prevention (including teenage pregnancy, STIs, HIV), addictions (alcohol, drugs), violence, Advocacy	Yes
Mexico	Should continue to support the development of life skills, focusing their use in key issues such as sexuality, HIV, STDs. addictions and alcoholism, but also working areas such as mental health (stress), and the drive towards positive health habits.	Yes
Nicaragua	Access to services of sexual and reproductive health for adolescents with specialized focus on preventing pregnancy, HIV through responsible sexual and reproductive behaviour attention	Yes
Honduras	-	-
Ecuador	-	No
Dominion Republic	Focused on advocacy to improve the quality of health services.	No
Peru	Strengthen the joint work of the Secondary Educational Institutions	Yes
South Asia & Pacific		
South Asia & Pacific Region	For me as WVB doing a great job in health , Nutrition and WASH activities and adolescent health can be blended with the activities already exits , we can go long run in 5 years,	Yes
Sri Lanka	SRH, Nutrition, disease prevention, protection, carrier guidance	Yes
India	We need to focus on implementing the existing policies and position ourselves as a credible partner at the state and country level to execute adolescent health program	Yes
Philippines	In the Philippines, more focus should be given on teenage pregnancy and HIV and AIDS since these cases are rising both in urban and rural settings.	Yes
West Africa		
Southern Africa		
Lesotho	WV adolescent health should be rolled out to other countries. Adolescents face serious health challenges and therefore addressing their health and development is very important to achieving MDGs since most of the MDGs are highly relevant to the health and welfare of youth. Improved adolescent health will directly contribute to achieving five of the eight MDGs: reversing the spread of HIV/AIDS; reducing maternal deaths; reducing infant and child death; developing and implementing strategies for decent and productive work for youth and reducing poverty.	Yes
Swaziland	Appropriate and consistent messaging and engagement in CSE should be the focus, enabling in and out of school youth targeted with a comprehensive curricula. Not rushing to reach a large number but comprehensive messaging and engagement	Yes
SARO	We need to work on life skills in and out of school children	Yes
MEER	Are we coordinating those activities, using experience, with for example UNFPA or even some parts with IPPF (even having in mind different approaches, especially regarding abortion, sexual rights, etc.)	Yes
WV Germany	Develop project model for adolescent health targeting sexual and reproductive health themes including menstrual hygiene, early marriage, unwanted pregnancies, violence etc. and to promote integration of adolescent health into routine service delivery package.	
WV US	WV should support abstinence and also recognize that if this is not possible, then adolescents need protection from pregnancy and STIs.	Yes
LACRO	Strengthening and empowerment of adolescents in their ability to self-care health, healthy lifestyles, life projects with a holistic view to education and opportunities that make viable economic choices and changing health behaviours and protective factors of the environment in their overall health that emphasizes sexual, reproductive, health proper nutrition, exercise, addiction prevention and prepare him for a full life	Yes
Australia program	Supporting place-based and culturally resonant initiatives that have community and especially youth buy-in, initiatives that enable youth participation- decision making and contributions.	Yes
Global Technical Team Humanitarian Operations	Adolescent Sexual and Reproductive Health should be of course at the forefront, this include mainly prevention of early pregnancy and advocacy on early marriages, protection for STIs and HIV. In addition, WV has to contextualize its Adolescent health programming as globally the major cause of mortality in adolescent is road traffic injuries and accidents, something around this needs to be done in the East African Region. Same for prevention of illicit drug abuse. In addition to or instead of only providing support services, WV may want to consider to directly deliver services	Yes

4.13 Project Experiences – case study example.

Cover of the Early Childhood and Teenage Pregnancy resource materials developed by the project

Maternidade Saudável como mecanismo de advocacy na Campanha Saúde para as Crianças Primeiro.

Healthy motherhood as advocacy mechanism in Child Health Now Campaign

2009 MOH data showed 20% of pregnant women Brazilian were teenagers. In addition it highlighted low antenatal attendance visits for adolescent mothers (3 visits or less) which increased risk of death and / or birth complications for mothers and their babies. The project used educational activities to prevent adolescent pregnancies and STI transmission. This was achieved through; development of materials including educational booklets (health adolescent kit and healthy maternity kit) and supporting school educators with topics in sexuality education; participatory approaches to help teenage mothers address physical pregnancy and psycho-social needs; by helping adolescents develop personal development plans; advocacy with government for developing comprehensive care programs for adolescents in prenatal, delivery and postpartum period; and by providing additional care and support for adolescent mothers and their infants. Results (2003 – 2009). 386 pregnant teenagers received prenatal care. Reduction in cases of malnutrition among pregnant women followed with reduced incidence of low weight of newborns. Increased adherence to breastfeeding and natural childbirth for most of adolescent mothers was achieved. Birth registration of more than 90% of children involved in the project was successful and about half of the assisted young people went back to school. The project increased awareness of teenagers about on responsible sexuality and care needed for a healthy and safe pregnancy, and importance of strengthening bonds between mother, child and families.

4.14 Project experiences – document review

Due to limited time and space, not all details can be included, and evidence of the impact and effectiveness of approaches was not done as the documentation available varied considerably.
Drop Box link to documents listed below: https://www.dropbox.com/sh/8baomgo7vsdornx/AADo4naOFEvx-cSnYt1rTrP0a?dl=0

National Offices	Project	Brief description	Sector focus
East Africa			
Kenya	Abstinence and Risk Avoidance for Youth Project Report (ARK). (End of project evaluation for Haiti, Kenya and Tanzania 2010)	The goal of ARK was to expand and strengthen HIV / AIDS prevention efforts for young people through behaviour change that will decrease risk of becoming infected – primarily through abstinence and being faithful (A&B) and mutual monogamy. The project offers young people a safe, enabling environment where small groups of youth, small groups of parents and Faith and Community Groups (F/CGs) can explore, foster, support and promote positive traditional norms of behaviour.	HIV prevention
	End of project evaluation; Youth Channels and Agents of Change July 2015	The goal of the Youth Channels and Agents of Change (YCAC) project was to empower 1,650 youths, including young women, to define and create change in their communities. More specifically, the project aimed at improving the uptake of family planning (FP) services and economic status by mobilising and empowering youths to be agents of change within their households and communities in four counties,	Youth leadership & SRH education (COH MNCH)
Tanzania	Abstinence and Risk Avoidance for Youth Project Report (ARK). (End of project evaluation for Haiti, Kenya and Tanzania 2010)	The goal of ARK was to expand and strengthen HIV / AIDS prevention efforts for young people through behaviour change that will decrease risk of becoming infected – primarily through abstinence and being faithful (A&B) and mutual monogamy. The project offers young people a safe, enabling environment where small groups of youth, small groups of parents and Faith and Community Groups (F/CGs) can explore, foster, support and promote positive traditional norms of behaviour.	HIV prevention
Burundi	RAMBA Project, B201527 (proposal in French not translated so refer to other documents relate to HIV Prevention among Children and Youths Project in Burundi)	This report covers activities implemented during the reporting period and progress made. The objectives of this project are as follows: promote HIV prevention through value based and age appropriate life skills for children and youths in targeted communities and schools (Primary and Junior Secondary school) in Bum ADP, Promote behavioural change for risk avoidance among children and youths. And also promote an enabling environment for positive behavioural change among children and youths.	HIV prevention
Middle East/Eastern Europe			
Afghanistan	Evaluation Report - Support for Street Children (SFSC) in Herat Project World Vision Afghanistan July 2014	WV established a centre for children working in the street, operating 6 days a week where children beneficiaries received a meal, remedial education classes, health care and psychological support through counselling sessions.	Youth Friendly centre (nutrition, health, educational and vocational training support)
Armenia	Improved Maternal and Child Health in Armenia Proposal 2010 – 2015 ADP	The goal of the proposed project is improved reproductive health of boys, girls and women of reproductive age and improved health care of young children by training front line project staff – yet to be evaluated	Maternal and Child Health
East Asia -			

Latin America/Caribbean			
Bolivia	Special Project - HIV prevention and AIDS "Chain of Light" 2010	Reduce the risk of HIV infection by raising awareness about ways to prevent and improve health conditions for PLWHA. Specific objectives • Provide information on HIV and AIDS to 3,000 adolescents and young adults 10-17 years of different areas of urban and peri-urban area of the city • To train 300 young health watchers who will be multipliers of information on HIV and AIDS. • Create a cast composed of young theatre PLWHA and youth who have received information about HIV and AIDS Mainstreaming in the works to introduce the subject of HIV and AIDS • Increase the number of youth voluntary rapid test are performed to HIV and AIDS in the department Santa Cruz (20%). • Create and strengthen support three self-help groups of people affected by HIV and AIDS at the departmental level.	HIV Prevention, Care & Treatment
Brazil	Systematization Methodology Healthy Maternity Healthy - Assorted documents and resources	The methodology Healthy Motherhood aims to promote educational activities for the prevention of early pregnancies and reduce the bio-psycho-social impact of teenage pregnancy. In this way it is structured in two policy fronts: • Education on sexuality for prevention of STDs and teenage pregnancies: proposes to conduct educational activities for adolescents within a comprehensive perspective in public schools or other community spaces • Education, Monitoring and facilitation of access to services for pregnant adolescents: proposes to organize a group of pregnant adolescents seeking to improve the exercise of a healthy motherhood, reflecting the care of the babies and the adoption of safe behaviours for both parties	Adolescent Sexual and Reproductive Health
Mexico	THE CHALLENGE - Adolescent Welfare Promotion – facilitator training guide	Youth leadership – to enable children aged 13 to 18 know the life skills and practical application in everyday life. The involvement of teachers, health workers, church people and the involvement of parents, positive reinforcement of the growth process of the participants is considered. Addressing various topics in 5 main themes (coexistence, alcohol, drugs, sexual and affective involvement), promotes thoughtful dialogue among peers and meeting with parents to improve communication and linkages, both family and community.	Youth leadership
Nicaragua	Final Report - Special Program Final Evaluation "Promotion of Sexual and Reproductive Health with emphasis on HIV, Siuna, June 2014	Sexual and Reproductive Promotion Project with emphasis on HIV was implemented from January 2009 to September 2013, which aims at Strengthening knowledge, attitudes, and practices in adolescents, youths, and population in general from the communities accompanied in terms of Sexual and Reproductive Health with emphasis on HIV to direct actions in the promotion of Sexual and Reproductive Health with emphasis on HIV jointly with local stakeholders from Siuna Municipality.	Sexual and reproductive health, HIV prevention
Honduras	Final Evaluation Report Pilot Project for the HIV Prevention Model in Children, Adolescents and Youths (CAYs) between the Ages of 5 to 18 years, based on Life Skills (LS) and Sexual and Reproductive Health (SRH) Education, implemented in Honduras and the Dominican Republic 2010	The HIV prevention model for CAYs between 5 and 18 years of age was developed from a review of the literature on the best practices for HIV prevention and the participatory community diagnostic where the problem and objectives tree was built with the participation of community leaders, ADP technicians, educators, health professionals and CAYs divided in two age groups, 8-11 and 12-18 years. Life skills and SRH education are the two pillars of the model.	HIV prevention, SRH education
Ecuador	Life skills training curriculum, 2007	Toolkit / Guide to raising awareness on health issues Sexual and Reproductive STI, HIV / AIDS and Indigenous Communities Using a grassroots framework, each community has its own ways of thinking about health, disease, sexual and reproductive rights, universal rights, and spirituality a tool kit, called "Living in HARMONY "(a term widely used in indigenous and Afro descendants) to working in	HIV prevention, SRH education

		the areas of sexual and reproductive health, STDs and HIV-AIDS 1; integrating in the process training-education to the community councils, families, organized groups, adolescents, children, within a framework of respect for the world view of indigenous peoples and reaffirmation Christian value	
Dominican Republic	Evaluation report Project: Operational Model of HIV Prevention in Children and Adolescents and Youth October 2010	This evaluation report Operating Model for HIV Prevention in Children, Adolescents and Young demonstrates a new approach to HIV prevention by building the HPV. The assessment shows that HPV strengthens protective factors in HIV prevention and reality states that contributes to strengthening capacity building in leadership and citizenship child and youth networks. The project model is a teaching-learning process on issues of HPV, SRH and HIV that combines four intervention strategies: 1. Parent Education; 2. Training for Sunday school teachers; 3. Training of mentors and mentoring project and 4. Appropriate use of leisure time through sports, art, recreation. These strategies are developed in four environments are in: home, church, child and youth centre and schools in order to ensure a positive environment for children, adolescents and youth	HIV prevention, youth leadership
	Final Evaluation Report Pilot Project for the HIV Prevention Model in Children, Adolescents and Youths (CAYs) between the Ages of 5 to 18 years, based on Life Skills (LS) and Sexual and Reproductive Health (SRH) Education, implemented in Honduras and the Dominican Republic 2010	The HIV prevention model for CAYs between 5 and 18 years of age was developed from a review of the literature on the best practices for HIV prevention and the participatory community diagnostic where the problem and objectives tree was built with the participation of community leaders, ADP technicians, educators, health professionals and CAYs divided in two age groups, 8-11 and 12-18 years. Life skills and SRH education are the two pillars of the model.	HIV prevention, SRH education
Peru	Project Design Document - Complementary Project "Building a Healthy and Responsible Sexuality" 20 May 2009 Strategy for training adolescent peer educators on healthy sexuality	The systematization of the experience of training peer educators in healthy adolescent sexuality, presented by the "Opportunity to a healthy sexuality" Project is the product of 36 months of intervention and simultaneous reflection of the work of World Vision International in Peru. Through participatory reconstruction; analysis of the strengths and weaknesses promoted during the implementation process, identifying execution paths and lessons focused on the role of the adolescents engaged in promoting a healthy and responsible sexuality based on Christian values.	Adolescent sexual and reproductive health peer education training
Haiti	Abstinence and Risk Avoidance for Youth Project Report (ARK). End of project evaluation for Haiti, Kenya and Tanzania 2010	The goal of ARK was to expand and strengthen HIV / AIDS prevention efforts for young people through behaviour change that will decrease risk of becoming infected – primarily through abstinence and being faithful (A&B) and mutual monogamy. The project offers young people a safe, enabling environment where small groups of youth, small groups of parents and Faith and Community Groups (F/CGs) can explore, foster, support and promote positive traditional norms of behaviour.	HIV prevention
South Asia & Pacific			
Solomon Islands	End of Project Evaluation - Honiara Youth Development, Employment and Small Enterprise Project (HYDESEP) Oct 2014	Honiara Youth Development, Employment, and Small Enterprise Project (HYDESEP). It commenced in October 2010 and finished in September 2014, and targeted 300 youth (200 females and 100 males). HYDESEP provided youth with life skills, technical capabilities and experience required to improve their livelihoods, through employment or business. HYDESEP was implemented in five Honiara communities where WVSI had ongoing development assistance experience	Vocational training
Bangladesh	End Evaluation Report - Juvenile Delinquents Project (B-176541) April 2014	World Vision Bangladesh "Juvenile Delinquents Project (JDP)" was under taken to serve the vulnerable children (the delinquents-drag addicted, accused for various anti-social activities). The objective of the project is to monitor the juvenile cases, and collect information about the juvenile offenders and follow-up the cases.	Juvenile justice

Indonesia	Final Report Vocational Training Centre 2010-2014	To reduce school drop out with early marriage by Life skills and competency development in • Self Discipline • Entrepreneurship • Leadership • Gender	Vocational training
West Africa			
Sierra Leone	HIV Prevention among Children and Youths Project 2009	The objectives of this project are as follows: promote HIV prevention through value based and age appropriate life skills for children and youths in targeted communities and schools (Primary and Junior Secondary school) in Bum ADP, Promote behavioural change for risk avoidance among children and youths. And also promote an enabling environment for positive behavioural change among children and youths	HIV prevention
Southern Africa -			