DOH

Adolescent Health and Development Program

MANUAL OF OPERATIONS

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With technical support from
World Health Organization - Philippines Country Office
(WHO-PHL)

Message from Secretary of Health

Paulyn Jean B. Rosell-Ubial, MD, MPH, CESO II

Adolescence (ages 10-19 years) is a period of rapid development. Physical, hormonal, neurological and psychosocial changes make this a time of adventure and learning. As health service providers, it is imperative that we ensure their health and safety while allowing them to learn and grow into well-informed, empowered, responsible and healthy citizens who are leaders in society.

In April 2000, the Department of Health's (DOH) Administrative Order 34-A, s. 2000 created the Adolescent and Youth Health Sub-program under the Children's Health Cluster of the Family Health Office. It was followed in 2006 by the creation of a Technical Committee composed of government and non-government organizations who was tasked to revitalize the program.

In recent years, issues such as early pregnancy, sexually transmitted infections, including HIV and AIDS, substance use disorders, violence, and mental illness threatened to derail the vision of adolescents becoming healthy and productive citizens of this country.

The DOH responded to these concerns by ensuring access to quality health care and services in an adolescent-friendly environment through directives such as Republic Act 10354 (also known as the Responsible Parenthood and Reproductive Health Act of 2012), the DOH Administrative Order 2013-0013 on the National Policy and Strategic Framework on Adolescent Health and Development, and other policies. Clearly, this is a manifestation of government's commitment to the health of Filipino adolescent.

To help those who manage adolescent health programs, the DOH, with support from the World Health Organization, developed this Manual of Operations (MOP). The MOP is a guide for program managers on the implementation of the National Policy and Strategic Framework on Adolescent Health and Development. This document includes tools such as the Standards for Adolescent-Friendly Health Services, the Competency Training on Adolescent Health for Health Service Workers, Adolescent Job Aid, and Guidelines for the Implementation of Adolescent Immunization, among others.

It is our hope that this manual will help local government units and civil society organizations to design and implement their own adolescent health and development program that is customized to their situation, priorities, and resources.

All for Health towards Health for All!

PAULYN JEAN B. ROSELL-UBIAL, MD, MPH, CESO II
Secretary of Health

Message from the WHO Representative in the Philippines

Dr. Gundo Aurel Weiler

Adolescent health has recently been given greater focus because of the ever growing health and development issues that young people face. According to the latest Global accelerated action for the health of adolescents (AA-HA!): Guidance to support country implementation, it is estimated that more than 3,000 adolescents die every day, around 1.2 million deaths a year, from largely preventable causes.

In the foreword of the Global Strategy for Women's, Children's and Adolescent's Health 2016-2030, the former United Nations Secretary General Ban Ki-moon emphasized the importance of bringing attention to adolescent health, saying that adolescents are "central to everything we want to achieve, and to the overall success of the 2030 Agenda". Promoting and protecting adolescent health leads to a healthy, prosperous and sustainable society. The Global Strategy, with its health priorities for women, children and adolescents to survive, thrive and transform, contributes to the Sustainable Development Goal (SDG) 3 to ensure healthy lives and promote well-being for all at all ages.

Adolescents, like all people from all age groups, should be given every opportunity to realize their rights to attain the highest standards of health and well-being, so that they will contribute to greater social and economic development. It is not sufficient that they survive; they should be ensured health and well-being (thrive); and ensured an enabling environment so that they will lead productive lives (transform). Adolescents who live healthy lives with access to proper health care and education have a better foundation to grow to their full potential as adults. The AA-HA! Guidance concluded that investing in adolescent health leads to triple dividend benefits for adolescents now, for their future adult lives, and for the next generation.

This initiative by the Department of Health to develop a Manual of Operations (MOP) for Adolescent Health and Development (AHD) is a laudable move and a step towards improved investment in adolescent health. With the local AHD managers as the audience, this manual will provide a more comprehensive, adolescent-friendly and acceptable health guidance to front liners on the ground.

We at the World Health Organization reaffirm our commitment to the vision of the Global Strategy for Women's, Children's, and Adolescent Health and the Sustainable Development Goals. Through the concerted effort of all sectors, we can make the vision of a healthier world a reality. I encourage not only the local AHD local managers, but all service providers who will read this document to apply and disseminate the step-by-step instructions and policies described in this MOP, and in their own field, make a direct contribution to sustainable health and development for the Filipino adolescents.

Gundo Aurel Weiler, MD PhD
WHO Representative in the Philippines

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• Department of Interior and Local Government (DILG)

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• President Roxas, North Cotabato
• Provincial Government of North Cotabato
• Provincial Government of Ilocos Norte
• Quezon City
• Iloilo City

Editorial and Publication Team

Abbreviations and Acronyms

ADEPT	Adolescent Health Education and Practical Training
AJA	Adolescent Job Aid
AHDP	Adolescent Health and Development Program
AIDS	Acquired Immune Deficiency Syndrome
ALS	Alternative Learning System
AO	Administrative Order
ASFR	Age Specific Fertility Rates
ASRH	Adolescent Sexual and Reproductive Health
BCPC	Barangay Council for the Protection of Children
BCC	Behaviour Change Communication
CEDAW	Convention on the Elimination of Discrimination Against Women
CHED	Commission on Higher Education
CHR	Commission on Human Rights
CRC	Convention on the Rights of the Child
CSO	Civil Society Organization
DepEd	Department of Education
DILG	Department of Interior and Local Government
DOH	Department of Health
DM	Department Memorandum
DSWD	Department of Social Welfare and Development
DCPB	Disease Control and Prevention Bureau
FDS	Family Development Sessions
FHO	Family Health Office
FHS	Family Health Survey
FP	Family Planning
FSW	Female Sex Workers
GF	General Fertility
GIDA	Geographically Isolated and Disadvantaged Areas
GSHS	Global School-based Student Health Survey
GYTS	Global Youth Tobacco Survey
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HSP	Health Service Providers
IAWG	Inter-agency Working Group
IRR	Implementing Rules and Regulations
KP	Kalusugan Pangkalahatan
LGBT	Lesbian, Gay, Bisexual and Transgender
LGU	Local Government Unit
LPPEd	Learning Package on Parent Education on Adolescent Health and Development
LSWDO	Local Social Welfare Development Office
MhGAP	Mental Health Gap Action Program
MHM	Menstrual Hygiene Management
MISP	Minimum Initial Service Package

MNCHN	Maternal, Newborn and Child Health and Nutrition
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MSM	Males who have Sex with Males
MSW	Male Sex Workers
NBI	National Bureau of Investigation
NCDPC	Non-communicable Disease Prevention and Control
NDHS	National Demographic and Health Survey
NGO	Non-government Organization
NIT	National Implementation Team
NNS	National Nutrition Survey
NSCP	National Smoking Cessation Program
NSO	National Statistics Office
PAM	Parenting the Adolescent Manual
PES	Parent Effectiveness Service
PGH	Philippine General Hospital
PhilHealth	Philippine Health Insurance Corporation
PLHIV	People Living with HIV
PNP	Philippine National Police
POPCOM	Commission on Population
PPS	Philippine Paediatric Society
PTCA	Parent, Teacher, Community Association
PWID	People Who Inject Drugs
RA	Republic Act
RH	Reproductive Health
RPRH	Responsible Parenthood and Reproductive Health
SC	Supreme Court
SCC	Smoking Cessation Clinic
SDG	Sustainable Development Goals
SDN	Service Delivery Network
SHAPE	Sexually Healthy and Personally Effective
STI	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities, and Threats
TESDA	Technical Education and Skills Development Authority
UHC	Universal Health Care
UN	United Nations
UNFPA	United Nations Population Fund
UNICEF	United Nations for Children's Fund
VAWC	Violence Against Women and Children
VCT	Voluntary Counselling and Testing (for HIV)
VYA	Very Young Adolescents
WB	World Bank
WHO	World Health Organization
YAFS	Young Adult Fertility and Sexuality Study
YDS	Youth Development Sessions
YKAP	Young key affected populations

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How the manual came about

The Department of Health (DOH) with the support of the World Health Organization- Philippines Country Office (WHO_PHL), convened an ad hoc committee to guide manual of operations development based on the Administrative Order 0013, -2013 National Health Policy and Strategic Framework on Adolescent Health and Development.

First draft was produced after extensive document review and visit to Metro Manila model local government units (LGUs) that had strong adolescent health services. Second draft was tested in a mock workshop in three urban areas, namely: Cainta Rizal, Caloocan City, and Quezon City. Participants included adolescent groups and representatives from local health departments, rural health units, and local social welfare and development departments. Results and suggestions from the workshop were incorporated into the third draft that was again reviewed by the ad hoc committee, selected non-government organizations (NGOs) and participating LGUs. A fourth draft containing comments and feedback were incorporated into the final draft for Phase 1. See Figure 1.

FIGURE 1. Phase 1 Draft consultations
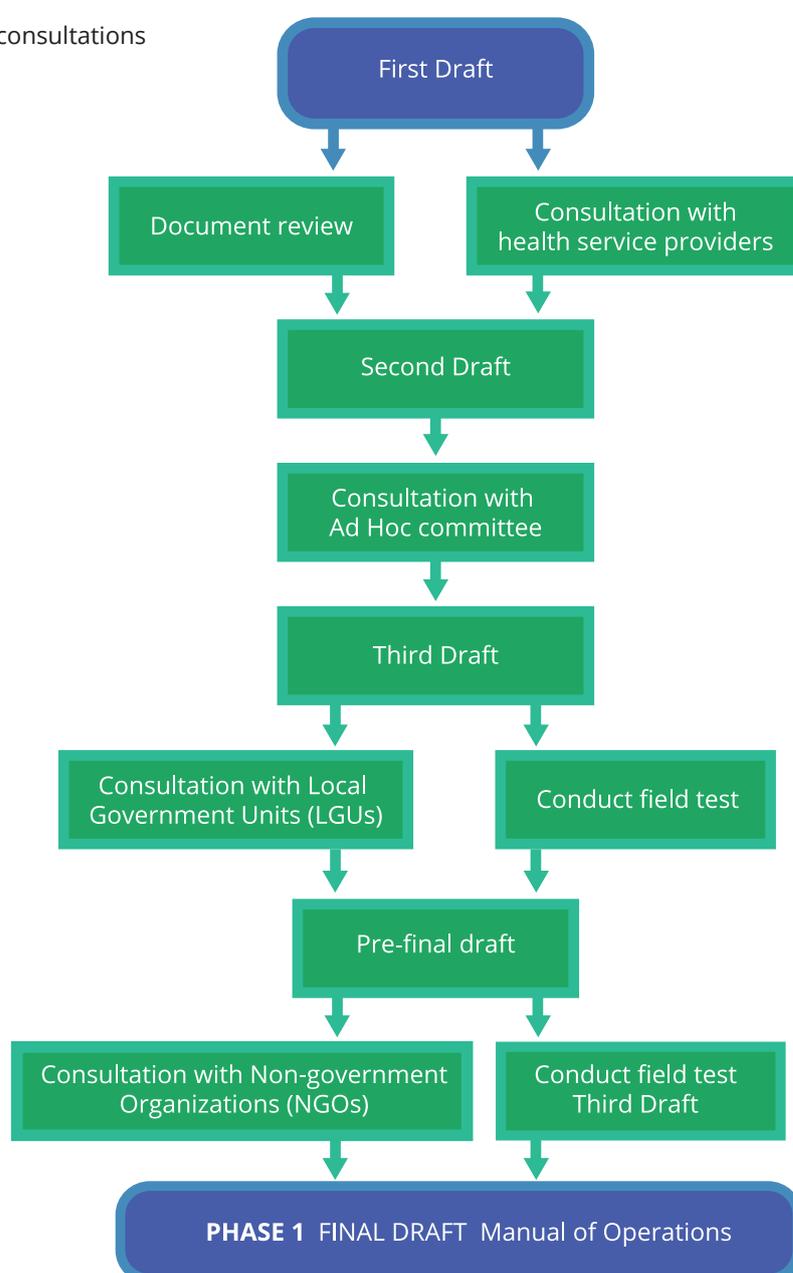
Phase 2 commenced in February 2016. This involved one-day orientation and testing of manual contents. It was conducted in two provinces, two municipalities and one city outside the Greater Metro Manila area. Health staff went through the manual section by section and provided comments specific to the manuals' structure, clarity, usability, and relevance to work.

Several other brainstorming sessions towards second and last quarter of 2016 and early 2017, were conducted to refine every content of the manual, including a final workshop of the AHDP technical working group, where the 2017 M&E Framework was included in the final draft.

The final draft was presented to the DOH Family Health Office (FHO), Disease Prevention and Control Bureau (DPCB) and the Responsible Parenthood and Reproductive Health National Implementation Team (RPRH-NIT) for approval. See Figure 2.

FIGURE 2. Phase 2 Final draft consultation and roll out
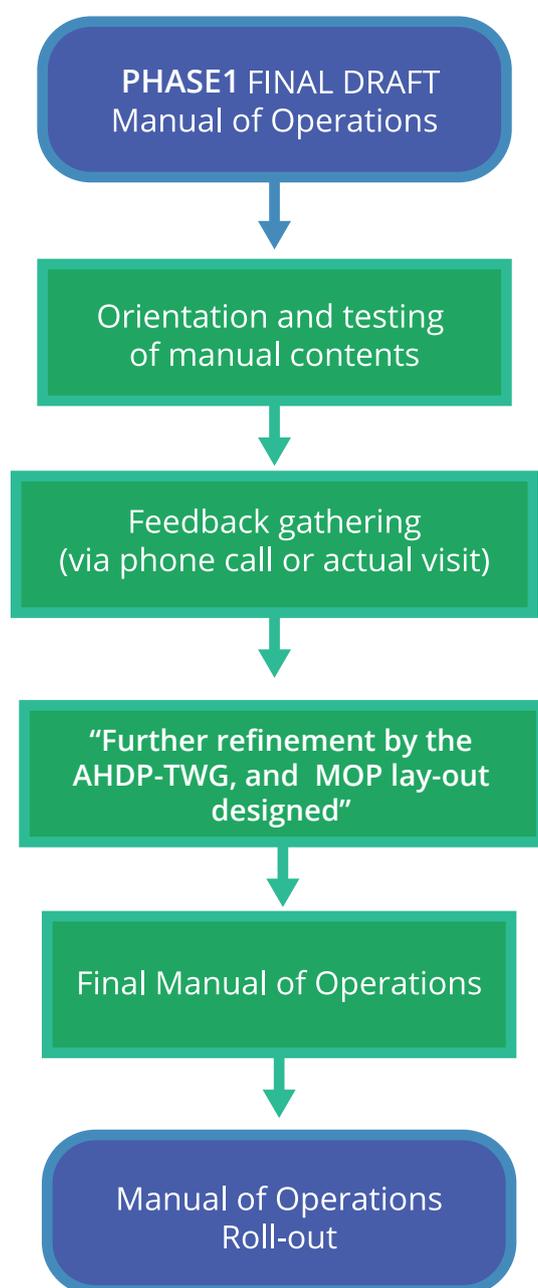
The Purpose of the Manual

This manual will be the guide on the implementation of the National Policy and Strategic Framework on Adolescent Health and Development (AHDP). Often services and interventions for adolescents exist separately and not necessarily part of a comprehensive and deliberately planned program. This manual offers a strategically planned program with clear, specific objectives to assist program managers, coordinators, and implementers to choose where to place resources. Also, this manual contains monitoring and evaluating measures to help track how the program is proceeding or progressing , and aid in decision-making.

It is intended for use of the following audience:

Program managers and coordinators: This manual is developed to help organizations, hospitals, or clinics who are with public, private sectors, and non- government to improve their programs on adolescent health and development. It focuses on information that managers might need to develop feasible and appropriate strategies, policies and evaluation plans.

Health professionals and non- health professionals: This manual is designed to provide practical recommendations and tools for health care and non-health organizations. It can also be used as reference requiring public health perspective or a health systems approach to managing adolescent health in their respective workplaces. Schools and youth groups who have had some experience in strategic planning process are welcome to use this manual for reference; however, they are strongly encouraged to complete basic training on adolescent health and development as well to gain full benefit of this manual.
This manual is not a clinical guide.

Frontline health workers, and those that diagnose and manage adolescents directly, are strongly encouraged to undergo the Adolescent Job Aid Training, and Adolescent Health Education and Practical Training (ADEPT) E-Learning Toolkit, conducted by DOH or one of its partner organizations. They are also strongly encouraged to consult other adolescent health manuals for more references. Also, this manual is not intended for peer educators and teachers who provide adolescent reproductive health and rights education. The manual does not contain messages for behaviour change and is not intended as a reference material on parenting adolescents.

Lastly, the use of the word development in the program title recognizes that a meaningful adolescent program involves more than behavioural risk reduction. This manual advocates and upholds the value of surrounding adolescents with a supportive environment, assisting with skills development to protect them from harm and prepare them for transition into adult roles. Education, livelihood, economic and other opportunities, though beyond the scope of this manual, are also recognized as important aspects of an adolescent development program affecting health.

How to Use this Manual

This manual is divided into eight sections, including the Annexes. The materials have been organized in sequential order so that the sections toward the beginning address the challenges encountered by the institutions or organizations that have just begun to address adolescent health and development programming, whereas the sections toward the end of the manual contain information and tools that are more relevant for organizations with more experience on adolescent health care. . In general, tools related to program design, and evaluation tools have been incorporated into the main body of the text, while surveys, protocols, and sample ordinances are located in the Annexes.

Briefly, the sections are organized as follows:

Section 1

The Context of Adolescents

This section talks about the biologic and psychosocial transitions. The section discusses both the importance and the challenges of educating health care providers about human rights, gender and the links between physical, emotional and social wellbeing of adolescents. It also looks at the ways in which an organization can lay the groundwork for improving the health care response to adolescents by ensuring that it is based on a human rights and public health perspective. It also provides a brief introduction to the issue of adolescent health and development, the reasons why the health sector should address this issue, the history of DOH's work in this area, and program considerations.

Specifically, the section includes the following subsections:
A. **Adolescence – a Unique, Formative Stage of Human Development**
   • Age Definitions
   • What is Special about Adolescents?
   • Vulnerable and Marginalized Adolescents
B. **Adolescent Health Situation: Global and in the Philippines**

Section 2

Overview of the Adolescent Health and Development Program in the Philippines

A. **Brief History of Adolescent Health and Development Program in the Philippines**
B. **AHDP Frameworks 2017**
   DOH Adolescent Health and Development Program Components
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D. **Laws and Policies**
   National Laws and Policies on the Rights and Responsibilities of Adolescents
E. **Gender and Sexual Orientation, and Gender Identity and Expression (SOGIE)**

Section 3

Program Development and Management

This section explores key elements of the planning and preparation stage for organizations that are just starting to implement the adolescent health and development program not only through the conventional public health lenses of risk and protective factors, bit also considers adolescents to be powerful societal assets whose contributions can be nurtured and augmented through meaningful engagement and participation. It also explains the importance of meaningful involvement of parents and community in the program development. It also provides recommendations for developing objectives, strategies, and monitoring and evaluation plans, as well as collecting baseline data.

Specifically, this chapter includes the following subsections:

A. **Meaningful Participation of Adolescents in Health Programming**
B. **Meaningful Involvement of Parents and the Community**

C. **Adopting the Program Development and Management Approach**
    Step 1: Organize a Working Group
    Step 2: Analyse the Situation / Conducting Rapid Diagnosis of the Situation
    Tool: Rapid situation diagnosis tool
    Step 3: Define Health Status and Behavioural Objectives
    Tool: Suggested steps for developing goals, and objectives
    Step 4: Identify Program Strategies
    Tool: Suggested steps for developing strategies
    Step 5: Develop an Activity Plan
    Tool: Suggested steps in the development of action plan
    Step 6: Assess and Evaluate
    Tool: Sample assessment monitoring and evaluation matrix

Section 4

Strategies for Improving the Adolescent Health and Development Program

This section presents recommendations and tools that any adolescent health care institution or organization can use to improve the quality of care it provides to adolescents in general and to vulnerable girls, boys, lesbians, gays, bisexuals, and transgender in particular. This section is designed to outline the key elements that should be considered by all organizations that provide health services to adolescent.

Specifically, this section includes the following sub-sections:

A. **Managing the Adolescent Health and Development Program**
    Tool: Management Checklist
B. **Ensuring Privacy**
C. **Strengthening Confidentiality**

D. **Enhancing Capacities of the Health Care Providers**
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Section 5

Standards for Quality Adolescent Friendly Health Services

This section presents recommendations and tools for health programs that are ready to implement adolescent friendly health services. This section is designed to assist health service providers and programmers in improving the quality of health-care services so that adolescents find it easier to obtain the health services that they need to promote, protect and improve their health and well-being.

Specifically, this section includes the following sub-sections:

A. **Delivery of Adolescent-Friendly Health Services**
B. **Global and National Standards on Adolescent-Friendly Health Services**
C. **Case Management Approach**
D. **Package of Adolescent Friendly Services**

Section 6

Building Service Delivery Network

This section provides a brief discussion of ways that health care organizations can reach beyond the organization, hospital, or clinic , and make arrangements to address adolescent health and development issues through legal advocacy and community education.

Specifically, this chapter includes the following subsections:

A. **Service Delivery Networks - Building Alliances with Other Agencies or Organizations**
B. **Setting up an Service Delivery Network for AHDP**
C. **Developing Referral Networks**
    Tool: Suggested steps for developing a referral directory

Section 7

Monitoring and Evaluation Tools

This contains the annexes and tools for the user. It also contains links to additional resources available online. At the end of the manual contains the National AHDP policy, blank worksheets used in Section 3, as well as various sample policies and tools for reference.

A. **Importance of Monitoring and Evaluation**
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Section 8

Annexes, Resources, and References

This section includes an annotated bibliography and a longer list of references for materials cited in this manual.

The Context of Adolescents

Early adolescence

10 -13

years old

Middle adolescence

14 -16

years old

Late adolescence

17 -19

years old

1.1 Adolescence – a Unique and Special Formative Stage of Human Development

Adolescence is a crucial period of psychological and biological change. It is second to early childhood in the rate and extent of developmental change. Puberty is initiated in late childhood through a series of hormonal changes that lead to sexual maturation and the capacity to reproduce. The resulting changes in sexual organs and production of sex hormones from these organs bring about the development of secondary sexual characteristics such as breast budding and growth of pubic hair. Changing sex hormones affect many changes in social interaction, sexual drive, attachment, and responses to stressors. Sex hormones also affect a wide range of nervous system processes.

In Erikson's eight stages of psychosocial development, teenagers face the challenge or task known as *Identity vs. Role Confusion*. They work at developing *a sense of self* by testing roles, then integrating them to form a single identity. Therefore, challenging adult authority is a healthy expression of identity.

Different parts of the adolescent brain mature at different speeds. While puberty drives most adolescents toward thrill seeking behaviours, the slow maturation of the cognitive-control system, which regulates these impulses, make adolescence a time of heightened vulnerability. This explains why educational interventions designed to change adolescents' knowledge, beliefs, or attitudes have been largely ineffective. A suggestion that changing the contexts in which risky behaviour occurs may be more successful than merely changing the way adolescents think about risk.
During adolescence, the rapid maturation of the brain and other biological systems combined with the social context serve to ingrain new behaviours, and allow many transitions important for an individual to function as a productive adult. This transition from childhood to adulthood is the central element of adolescence.

The brain and body processes that occur at the same time make puberty complex. Physical maturation pushes an individual into adolescence with peaks in strength, speed, and fitness. Yet puberty also triggers emotional, thinking, and behavioural changes. *These biological processes are beyond the control of the individual and it is important to keep these in mind when working with adolescents*.

1.2 Age Definitions

Republic Act (RA) 10354, the Responsible Parenthood and Reproductive Health (RPRH) Act of 2012 uses the term adolescents for people aged 10-19 years. This distinguishes the term from youth for those aged 15–24 years and young people for that aged 10-24 years. In the Philippines, adolescents comprise 21.5% of the country's population (NSO, 2010).

This manual focuses on the programs that cater to adolescents aged 10-19 years.

The Department of Health (DOH) and the Philippine Paediatric Society (PPS) divides this period into:

- Early adolescence: 10-13 years old
- Middle adolescence: 14-16 years
- Late adolescence: 17-19 years

At each stage, adolescents have unique realities and have different concerns. For example, girls in early adolescence may have just begun menstruating and are concerned with menstrual hygiene. In comparison, girls in late adolescence are probably concerned with romantic relationships (or their lack of one). Also, early adolescents attending schools have unique concerns compared to late adolescents who may have already entered the workforce.

Relevant Acts for consideration include:

- **RA 10630 (Juvenile Justice Act)** defines age of criminal responsibility at 16 and above

- **RA 7658 (Prohibiting the Employment of Children Below 15 Years of Age in Public and Private Undertakings)** - prohibits the employment of children under 15 years

- **RA 8504 (Philippine AIDS Prevention and Control Act of 1998)** - requires written informed consent from parents or legal guardians of minors for HIV testing

Furthermore, under Philippine law, the legal age for marriage is 18. If the contracting parties are between the ages of 18 and 21, they must present written consent to the marriage from their father, mother or legal guardian.

The government recognizes the leadership and participation of adolescents, young people and the youth as essential in nation building. Older adolescents are often preparing for entry into the workforce.   They are essential to the national and economic development, considering their potential for employment, whether in the formal or informal sectors.

1.3 What is Special about Adolescents?

Adolescence is one of the most rapid and formative phases of human development, and the distinctive physical, cognitive, social, emotional and sexual development that takes place during adolescence (Figure 3) demands special attention in national development policies, programmes and plans.

FIGURE 3. What is Special about Adolescents?

Rapid physical, cognitive, social, emotional and sexual development	Widening gap between biological maturity and social transition to adulthood	Balance between protection and autonomy
• Hormonal changes and puberty • New and complex sensations and emotions • Sexual awareness and gender identity • Burst of emotional and physiological brain development • Enhanced and evolving cognitive ability • Context-influenced emotional impulse control	• More years in education and training due to the expansion of primary, secondary and further education • Later onset of employment and family formation • More independent involvement in health services, which may be ill prepared to serve adolescents with special needs	• Emerging autonomy but limited access to resources (e.g. finances, transportation) • Appropriate representation in decision-making bodies • Rights to consent to services, commensurate with evolving capacity • Increased vulnerability to some aspects of globalization (e.g. increased vulnerability to gaming, pornography. online bullying)

1.4 Vulnerable and Marginalized Sub-Groups

Adolescents need access to quality adolescent friendly services provided by managers, coordinators, and clinicians trained to work with this population group. Comprehensive sexuality education programs should offer accurate and comprehensive information that assists in building skills for negotiating sexual behaviours. Girls, boys, and lesbian, gay, bisexual, transgender, and queer (LGBTQ) groups need equal access to adolescent development programs that connect them to supportive adults and with educational and economic opportunities.

> ## Vulnerability
> • Refers to factors that make a person more susceptible to poor health outcomes
> • In contrast, risk is defined as the likelihood that a person may acquire a disease.

However, there are adolescents who are more vulnerable to risky behaviour and exploitation than the general adolescent population. It is important that they are identified. DOH Administrative Order No. 2013-0013 emphasizes equity and inclusion of the following marginalized groups:

- Abandoned and neglected adolescents and adolescents on the streets
- Adolescents in commercial sexual exploitation
- Adolescents (Children) in conflict with the law
- Adolescents in geographically isolated and disadvantaged areas (GIDA)
- Adolescents in indigenous communities
- Adolescents in hazardous work
- Adolescent survivors of calamity and disasters
- Adolescents in situations of armed conflict
- Adolescent survivors of abuse and exploitation

- Adolescents (Persons) with disability
- Lesbian, gay, bisexual, transgender and queer (LGBTQ) adolescents
- Out-of-school adolescents
- Substance dependent and addicted adolescents (including alcohol, drugs and tobacco)
- Adolescents or Young key affected populations (YKAP) which includes males who have sex with males (MSM), sex workers, and people who inject drugs (PWID)

These marginalised sub-groups may not have access to basic health services and may be discriminated against when availing of these services. Often, they can be vulnerable to a combination of the following conditions:

- Assault, bullying and exploitation
- Abortion, sexual exploitation, unwanted and unsafe pregnancy, sexually transmitted infections such as, gonorrhea Chlamydia, genital candidiasis, and HIV and AIDS ,and unplanned motherhood
- Various other infectious diseases
- Alcohol, drugs, smoking and substance abuse

- Common infections
- Malnutrition or nutritional disorders,
- Occupation-related diseases and injuries
- Physical abuse and injuries, violence
- Road accidents,
- Self-inflicted harm

They are also at risk for lifestyle-related diseases, such as cardiovascular and liver disease, later in life.

1.5 Adolescent Health Situation: Globally and in the Philippines

Adolescents are exposed to various dangers due to their increased mobility and risk-taking behaviors. Many adolescent disease and injury burdens are preventable or treatable, but are often neglected. They require a sustained focus and investment. In 2015, more than 1.2 million adolescents died. Road injury was the leading cause of death in both young and older adolescent males, but for females the leading cause of death changes from lower respiratory infections among younger adolescents to maternal conditions among older adolescents. Selected risk factors for disease burdens have been studied by the 2013 Global Burden of Disease Study.1

However, according to WHO the leading risk factors in this older age group also include risk behaviours, such as alcohol use, unsafe sex and, to a lesser extent, drug use. Other risk factors that are only leading risk factors among older adolescents are intimate partner violence and occupational hazards such as exposure to toxins or work-related injuries. It is important to remember that some types of risk or protective factors that may be very important, such as those related to family or school, were not included in the risk factors studied. Some adolescents are particularly vulnerable, experiencing higher exposure to health risks, lower access to health services, worse health outcomes and greater adverse social consequences as a result of ill health. Adolescent health inequalities are often influenced by factors such as sex, income, education and rural or urban residence.

Particularly vulnerable adolescents include those who are:

- Living with disabilities or chronic illnesses;
- Living in remote areas or caught up in social disruption from natural disasters or armed conflicts:
- Stigmatized and marginalized because of sexual orientation, gender identity or ethnicity;
- Institutionalized, or exposed to domestic violence or substance abuse in the family;
- Exploited and abused;
- Married, or who migrate for work or education without family or social support;
- Exposed to racial or ethnic discrimination;
- Not in education, employment or training;
- Not able to have access to health services or social protection.

Burden and Risk Factors Pertaining to Adolescents in the Philippines

Violence

is also prevalent in this age group. Sixteen percent (16.6%) of women age 15-19 have experienced physical violence at least once in their life and 4.4% are survivors of sexual violence. Seventeen percent (17%) of Young Adult Fertility and Sexuality Survey in 2013 (YAFSS) adolescent respondents have experienced violence in the past year, and 23 % have been aggressors of violence between the aged 15 – 24 years old. Almost half (47.7%) of 13-15 year old schoolchildren in the 2013 Global Scholl Health Survey (GSHS) have experienced bullying and 4.8% of YAFSS adolescents have been harassed using technology.

FIGURE 4: Violence experienced by girls and boys aged 15- 24 years old:

Proportion of youth (15-24) who have been *aggressors* of violence **%**
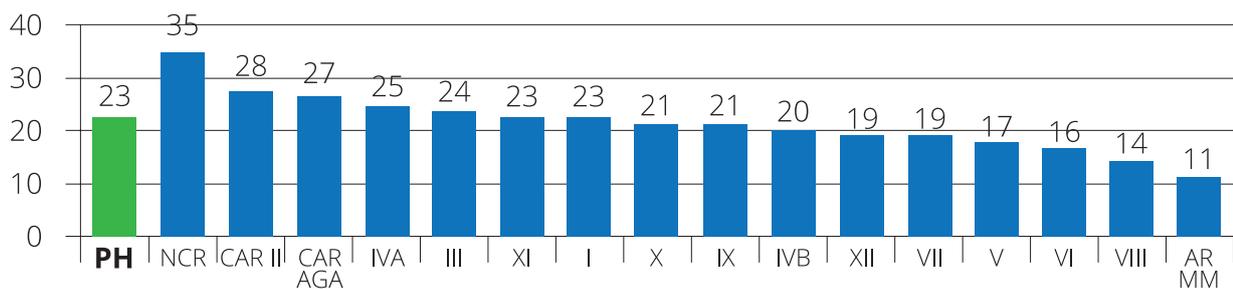
Proportion of youth (15-24) who have been *victims* of violence   **%**
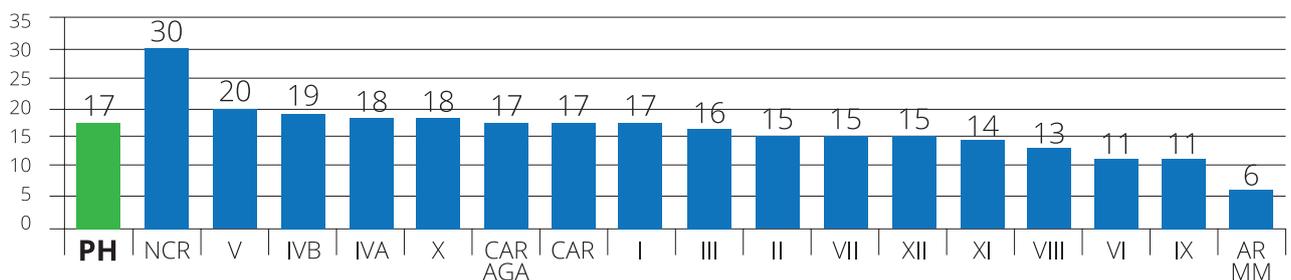
Source: Demographic Research and Development Foundation or YAFSS 2013

Substance Use, Alcohol, and Tobacco

Adolescents are vulnerable to the harmful effects of **alcohol, tobacco, and illegal substances.** In the 2013 National Nutrition Survey (NNS), 6.8% of adolescents are current smokers and 5.7% are former smokers. Fifteen percent (15.6%) of YAFSS (2013) respondents are current smokers and 2.6% have ever used drugs. In YAFSS, 8.1% of adolescents 15-19 years old have ever passed out drunk. The 2015 Global Youth Tobacco Survey (GYTS), together with Global School Based Health Survey (GSHS) and YAFS describe other risk behaviors. In 2015, GSHS found that 18.2% of schoolchildren 13-15 years old have experienced being really drunk at least one drinking alcohol once one or more days during the past 30 days. According GSHS, 11.0% have smoked cigarettes in the past month. In 2015, GYTS analyzed that a total of 16.0% of the respondents currently use any tobacco product (smoked tobacco and/or smokeless tobacco) and 28.1% of students are ever tobacco users.

FIGURE 5. Alcohol and drug use among high school students, aged 13-15 years:
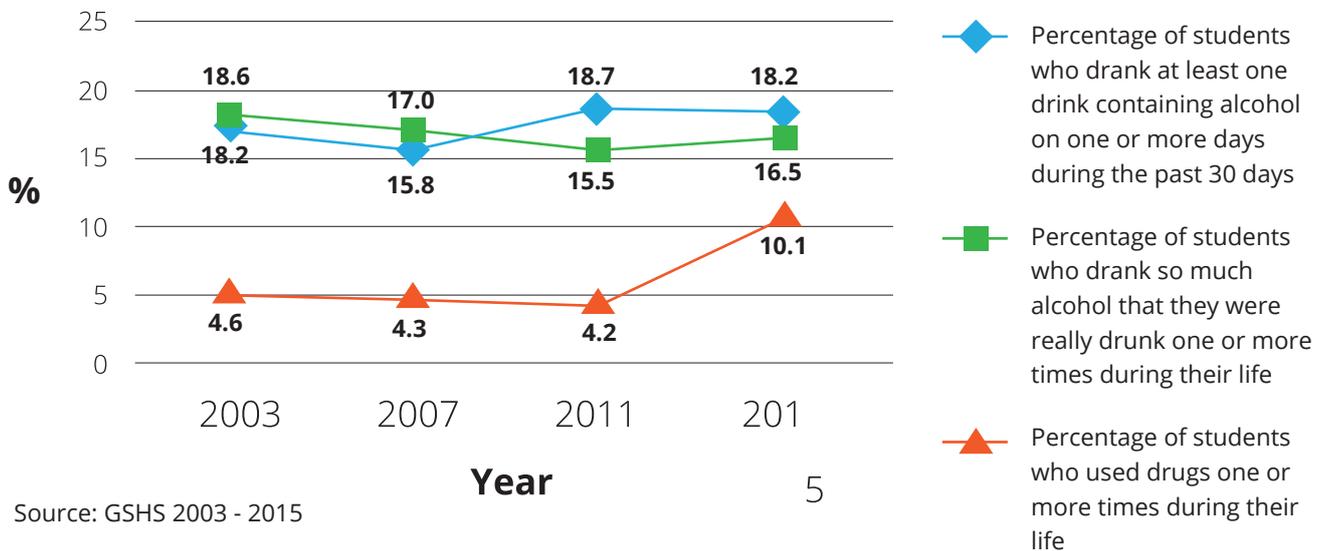
Source: GSHS 2003 - 2015

FIGURE 6. Ever cigarette smoker and current tobacco user among students 13-15 years old
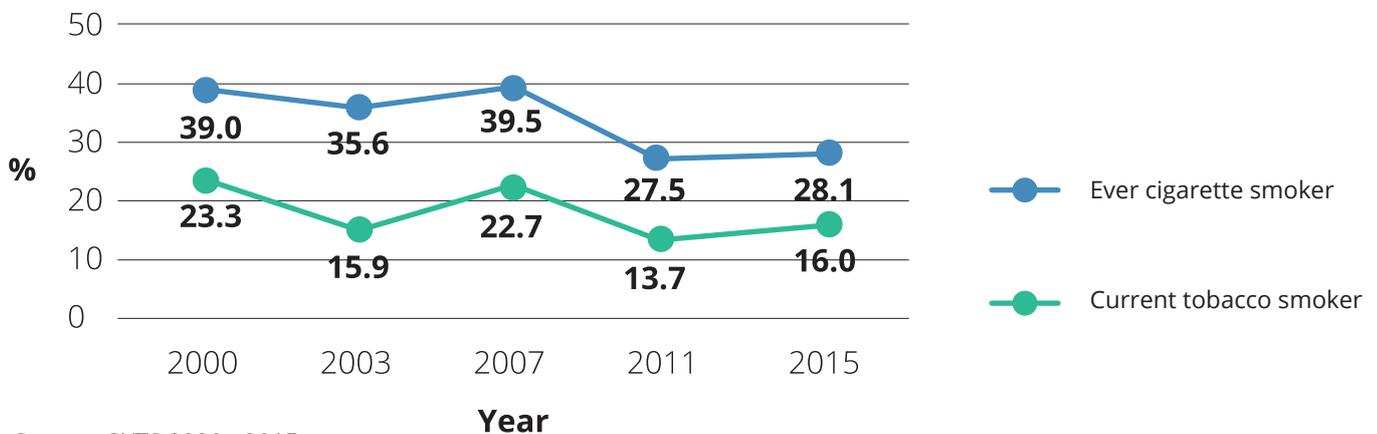
Source: GYTS 2000 - 2015

Malnutrition

is a double burden with 12.4% of adolescents wasted and 8.3% overweight or obese. The latter is somewhat expected given that 42.2% consume soft drinks one or more times per day while only 13.9% were physically active for a total of at least 60 minutes daily on five or more days during the past week. On the other hand, one in three (37.2%) pregnant adolescents are nutritionally at risk (based on weight-for-height classification, P<95).

FIGURE 7. Filipino youth (15-24) assessment of their health status:

1%
7%
16%
49%
27%

- ■ Very healthy
- ■ Healthier then average
- ■ Average
- ■ Somewhat healthy
- ■ Very unhealthy
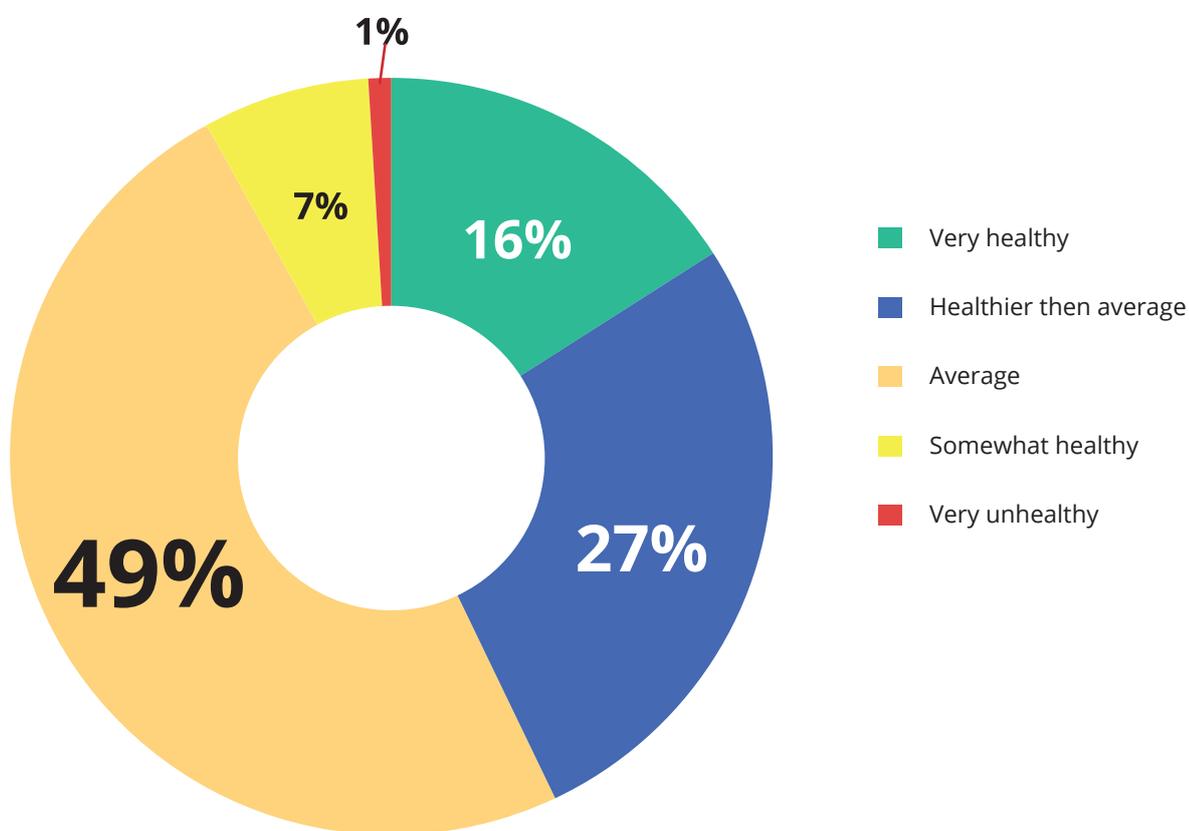
Source: Demographic Research and Development Foundation and YAFSS 2013

Sexual and Reproductive Health

issues are a growing cause for concern. While General Fertility (GF) has significantly decreased since 1970, Age Specific Fertility Rates (ASFR) of adolescents has changed little. The 2013 National Demographic and Health Survey (NDHS) places adolescent ASFR at 57 livebirths per 1,000 women 15-19 years old, up from 54 in the 2008 NDHS. According to YAFSS 4, data shows that in the Philippines, an increasing proportion of adolescents and young people have early sexual encounters. In 2013, 1 in 3 young people report having premarital sex. The prevalence of early sexual encounters has increased over the last 20 years. Males are more likely to report having premarital sex than females. In 2013, 36% of males reported having early sexual encounters compared to 29% of females. The highest levels of early sexual encounters are reported in NCR (41%) & Central Luzon (31%) regions. Also, many young people marry young, and it is important that they have good information before they are married so that they can make healthy, informed decisions.

FIGURE 8. Number of Births to Women 10-19 years old
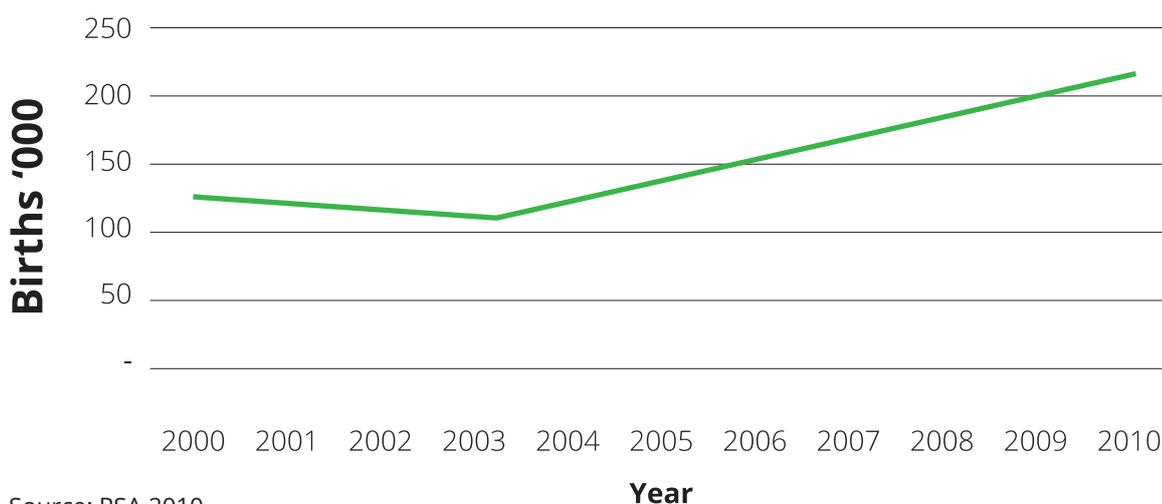
Source: PSA 2010

According to the YAFSS, 13.6% of girls 15-19 years old have begun childbearing, up from 6.3% in 2002. Early onset of sexual activity is prevalent. Seventeen percent (16.9%) of 15-19 year olds has had sex and only 79% of them used contraception during their first sexual encounter.

Maternal mortality rates for women age 15-19 for the 0-6 years period preceding the 2011 Family Health Survey (FHS) are lower (53 per 100,000 livebirths) compared to older women. However, children born to mothers less than 20 years old have higher neonatal, infant, and under-five mortalities than those born to older mothers.

HIV and AIDS

In April 2017, there were 629 new HIV antibody sero-positive individuals reported to the HIV/ AIDS & ART Registry of the Philippines (HARP) [Table 1]. More than half were from the 25-34 year age group while 30% were youth aged 15-24 years. 33 adolescents aged 10-19 years were reported. All were infected through sexual contact (8 male-female sex, 19 male-male sex, 6 sex with both males & females).

From January 1984 to April 2017, 1,606 (4%) of the reported cases were 19 years old and below. Seven percent (111 out of 1,606) were children (less than 10 y/o) and among them, 108 were infected through mother-to-child transmission, 1 through blood transfusion and 2 had no specified mode of transmission. Ninety-three percent (1,495 out 1,606) were adolescents. Among these, 1,359 (91%) were male. Most (93%) of the adolescents were infected through sexual contact (185 male-female sex, 843 male-male sex, 367 sex with both males & females), 85 (6%) were infected through sharing of infected needles, 8 (<1%) through mother-to-child transmission, and 7 had no specified mode of transmission (Figure 9).

TABLE 1. Quick Facts on HIV and AIDS

Demographic Data	Apr 2017	Jan-Apr 2017	Jan 2012 - Apr 2017	Cumulative Jan 1984 - Apr 2017
Total Resported Cases	629	3, 290	34, 548	42, 912
Asymptomatic Cases	545	2, 914	31, 489	38, 871
AIDS Cases	84	376	3, 059	4, 041
Male	596	3, 131	33, 042	39, 932a
Female	33	159	1, 506	2, 969 a
Age Range (Median)	2-79 (27)	1-79 (27)	1-82 (28)	1- 82 (28)
Less than 15 y/o	2	10	63	121 b
15-24 y/o	190	1, 020	9, 823	11, 740 b
25-43 y/o	323	1, 653	18, 231	22, 039 b
35-45 y/o	97	529	5, 649	7, 769 b
50 y/o & above	17	78	782	1, 169b
Pregnant WLHIV	6	21		170
Newly Started or ART	561			
Total PLHIV on ART				19, 653
Reported Deaths	17	172		2, 141

Source: DOH HIV AIDS and ART Registry of the Philippines April 2017

FIGURE 9. Modes of Transmission among children and adolescents
January 1984 – April 2017 (N = 1, 606)

- Sex with both Males & Females
- Male-Female Sex (F)
- Male-Female Sex (M)
- Male-Male Sex
- Sharing of Infected Needles
- Mother-to-Child Transmission
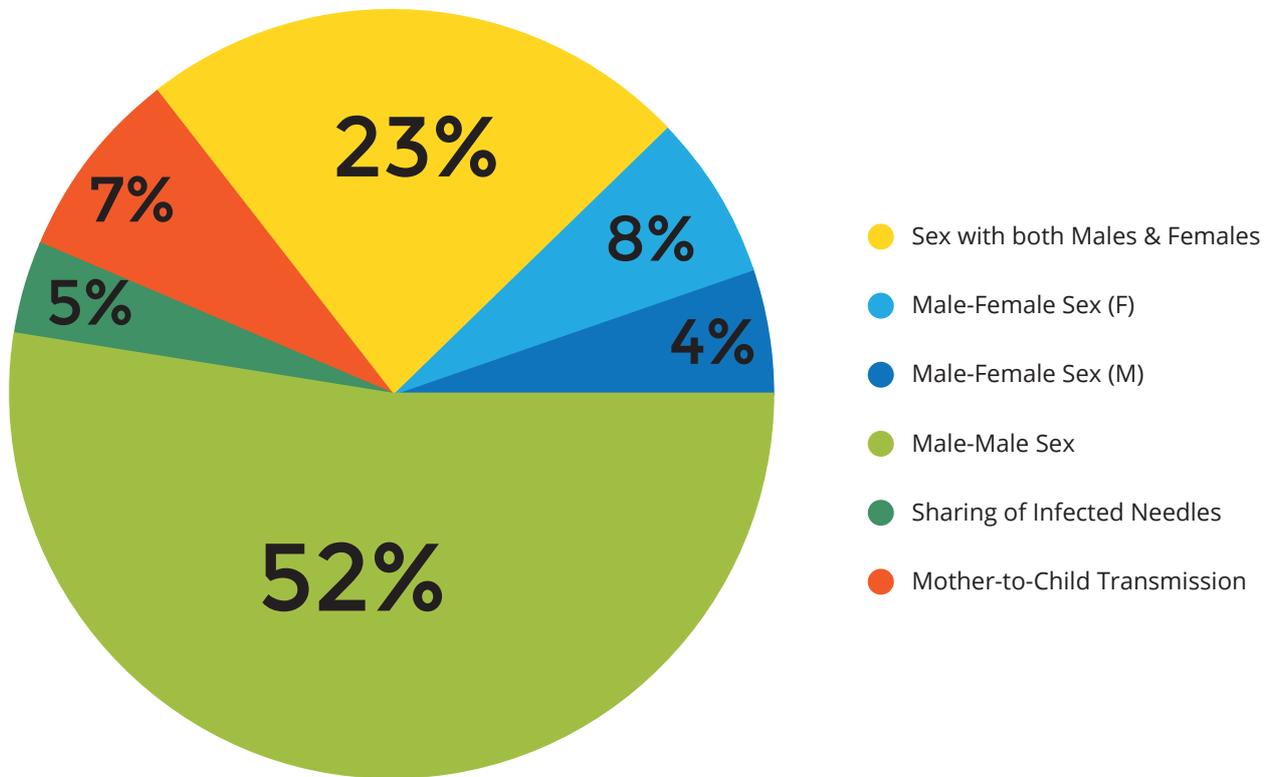
Because HIV is only transmitted in certain ways, those people who engage in particular behaviours are at much higher risk of HIV transmission. These populations are known as 'key populations at higher risk of HIV exposure' and require targeted programming. Young people from these populations are especially vulnerable because they may be more likely to have unprotected sex with many partners or to share syringes for drug use. In the Philippines, key populations include:

- People who inject drugs
- Men who have sex with men
- Transgender
- Sex workers

Because these groups are at higher risk, it is important to target these groups with programs that help them learn how to protect themselves against HIV and to ensure that they have good access to HIV testing and counselling services and treatment options where needed.

Adolescents' channels of communication are also important in programming. Among YAFSS respondents 15-24 years old, the most common leisure activities are watching television (49%), followed by texting (30%) and listening to music (27%). More than half (53.9%) have a social networking account, 75.2% own a cellphone, 60.4% use internet, 52.4% have email, and 2.1% have a blog. Virtual friendships are a norm, with 31% having online friends and have not seen personally and 25% have text mates who they have not seen personally. There is increasing concern about the risks this trend poses to adolescents. Problematic and risky internet use is undoubtedly an emerging issue in need of further study.

YAFSS respondents preferred to learn about sex and reproduction from friends of the same sex (60%), medical professionals (43%) and their own mother (34%). Half of females (50%) would like to learn about sex and reproduction from their own mother, the corresponding proportion for males is 18.5%.

Section 2

Overview of Adolescent Health and Development Program in the Philippines

2.1 Brief History of Adolescent Health and Development Program in the Philippines

In April 2000, DOH issued the Administrative Order 34- A s 2000, the Adolescent and Youth Health (AYH) Policy, creating the Adolescent Youth Health Sub-program under the Children's Health Cluster of Family Health Office. In 2006, the department created the Technical Committee for Adolescent and Youth Health Program, composed of both government and non-government organizations dedicated to uplifting the welfare of adolescents and tasked to revitalize the program.

Due to an increasing health risky behaviour among our Filipino adolescents, DOH embarked on revising the policy and to focus on the emerging issues of the adolescents which are the 10 – 19 years old. In March 21, 2013, DOH with the support of the United Nations Population Fund (UNFPA) Philippines, revised the policy and served the Administrative Order 0013, -2013 National Health Policy and Strategic Framework on Adolescent Health and Development (AHDP). The Strategic Framework 2013 (Figure 10) is designed in accordance with this goal.

AHDP's Goal

is to improve the health status of adolescent and to enable them to fully enjoy their right to health

AHDP's Vision

is a country with well-informed, empowered, responsible and healthy adolescents who are leaders in society.

AHDP's Mission

is to ensure that all adolescents have access to quality comprehensive health care and services in an adolescent – friendly environment

Achievement of these health outcomes is built upon behavior change, including increased service utilization, adoption of healthy behaviors, avoidance of risky behaviors, and participation in community development. These behaviors are enabled by strategies such as access to quality services, health insurance for adolescents, skilled health service providers, families, and adolescents, new and stronger partnerships, information management, and policy support. In turn, these strategies are built upon actionable program components, which include the process of achieving adolescent-friendly health services, financing, capacity building, monitoring and evaluation, research, partnership building, and advocacy. These elements are non-linear as multiple health and development goals call for a range of interventions delivered in an integrated manner.

FIGURE 10. AHDP Strategic Framework 2013

FIGURE 10. AHDP Strategic Framework 2013

Well-informed, empowered, responsible and healthy adolescents who are leaders in society	Vision

Improved Health Status	Adolescents able to enjoy their right to health	Overall Goals

Increased Service Utilization	Adoption of Healthy Behaviors	Avoidance of Risky Behaviors	Participation in Community Development	Behavioral Objectives

Access to quality services	Health insurance for adolescents	Skilled service providers, families and adolescents	New and stronger Partnerships	Information Management	Policy Support	Strategies

Adolescent-Friendly Services	Financing	Capacity Building	Monitoring and Evaluation	Research	Partnership Building	Advocacy	Program Components

2.2 AHDP Framework 2017

In 2015, DOH AHDP Program Manager revived the National External Technical Working Group (TWG) on AHDP. This is composed of different stakeholders from the government, non-government, academe, and youth – led organizations. In 2016, DOH recognized the need for harmonization of programs within the department that caters 10 – 19 years old. The AHDP Program Manager convened the first DOH – Internal Technical Working Group. This aims to ensure that all programs are working together for the betterment of the adolescents in the country. It is also an avenue to discuss indicators, policies, strategies, and service delivery at the national and local implementation levels. The External and Internal TWGs on AHDP are multi -sectoral, collaborative approaches to fulfil the goal, vision, and mission of the program. In 2017, both TWGs revised the strategic framework, and developed a logical framework, and monitoring and evaluation framework of the program.

FIGURE 11. Philippine Youth Development Plan Framework

Cluster Categories
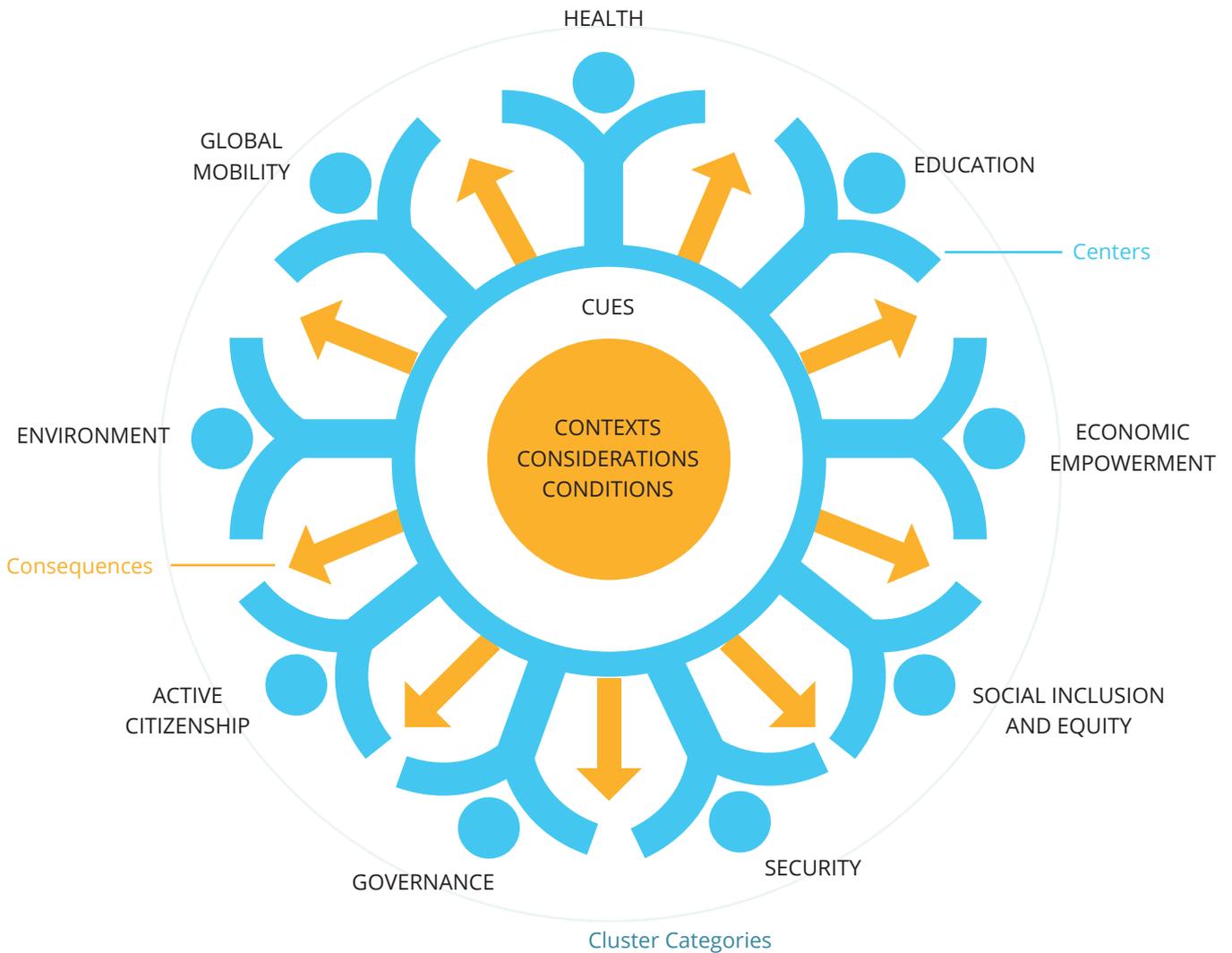
The Philippine Youth Development Plan Framework is the basis of the revision and development of the AHDP Strategic Framework early 2017. The National Youth Commission (NYC) as the head of the AHDP External Technical Working Group, is now ensuring the AHDP will be a priority and must be a cross-cutting concern to all Centers and Cluster Categories of PYDP.

FIGURE 12 AHDP Strategic Framework 2017
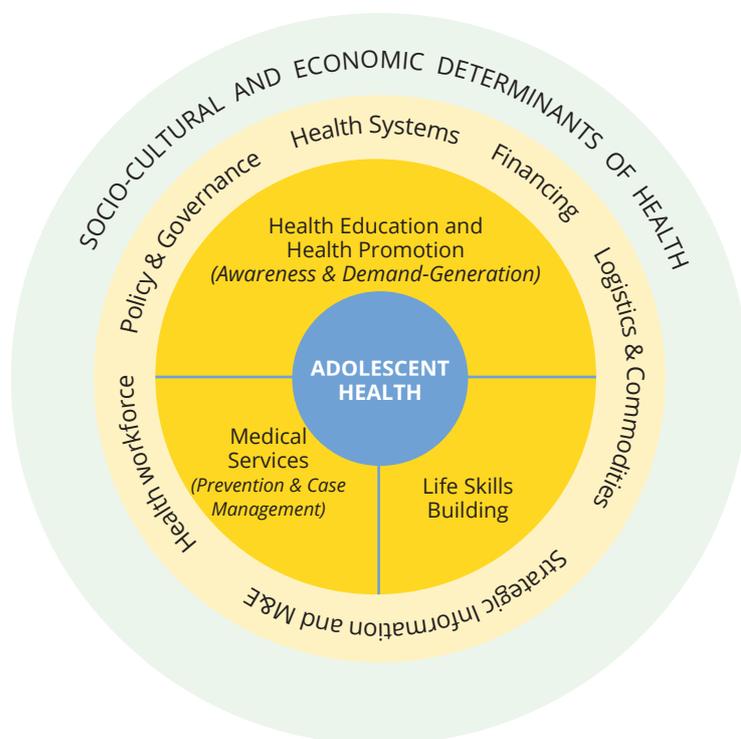
The center of the strategic framework of AHDP illustrated in Figure 12 is the Adolescent Health, surrounded by the three core strategies: health education and health promotion, life skills building, and provision of prevention and case management medical services.

To implement these strategies effectively, the health systems building blocks must be in place. There should be available facilities, logistics and commodities as part of the supply. The health and non-health workforce should also be capable and adequate in number and resources, to deliver the needed services. Adequate financing should be in place to support implementation of strategies. There should be an enabling environment in the form of facilitative policies and supportive decision-makers. Lastly, strategic information should be available as well as regular monitoring and evaluation mechanisms of the Adolescent Health and Development Program (AHDP).

Beyond the health systems, there are other socio-cultural determinants of health that affect adolescent health directly or indirectly. These include education, livelihood, active participation. Lastly, cross-cutting barriers are present that may hinder the achievement of the goals of adolescent health.

All of these elements were taken into account in planning for the AHDP strategies.

Logical framework

The desired impact of the AHDP is to prevent morbidities and mortalities among adolescents. To prevent morbidities, an array of prevention services should be provided. These services include provision of health education, life-skills building, health promotion of available services, and provision of actual prevention services. If successful, these will increase the knowledge of adolescents on the health condition, disease, available services; lead to the avoidance of risky behaviors, and practice of protective behaviors among adolescents and utilization of prevention services. Ultimately these outcomes could lead to the prevention of morbidities in this age group.

FIGURE 13. Logical Framework
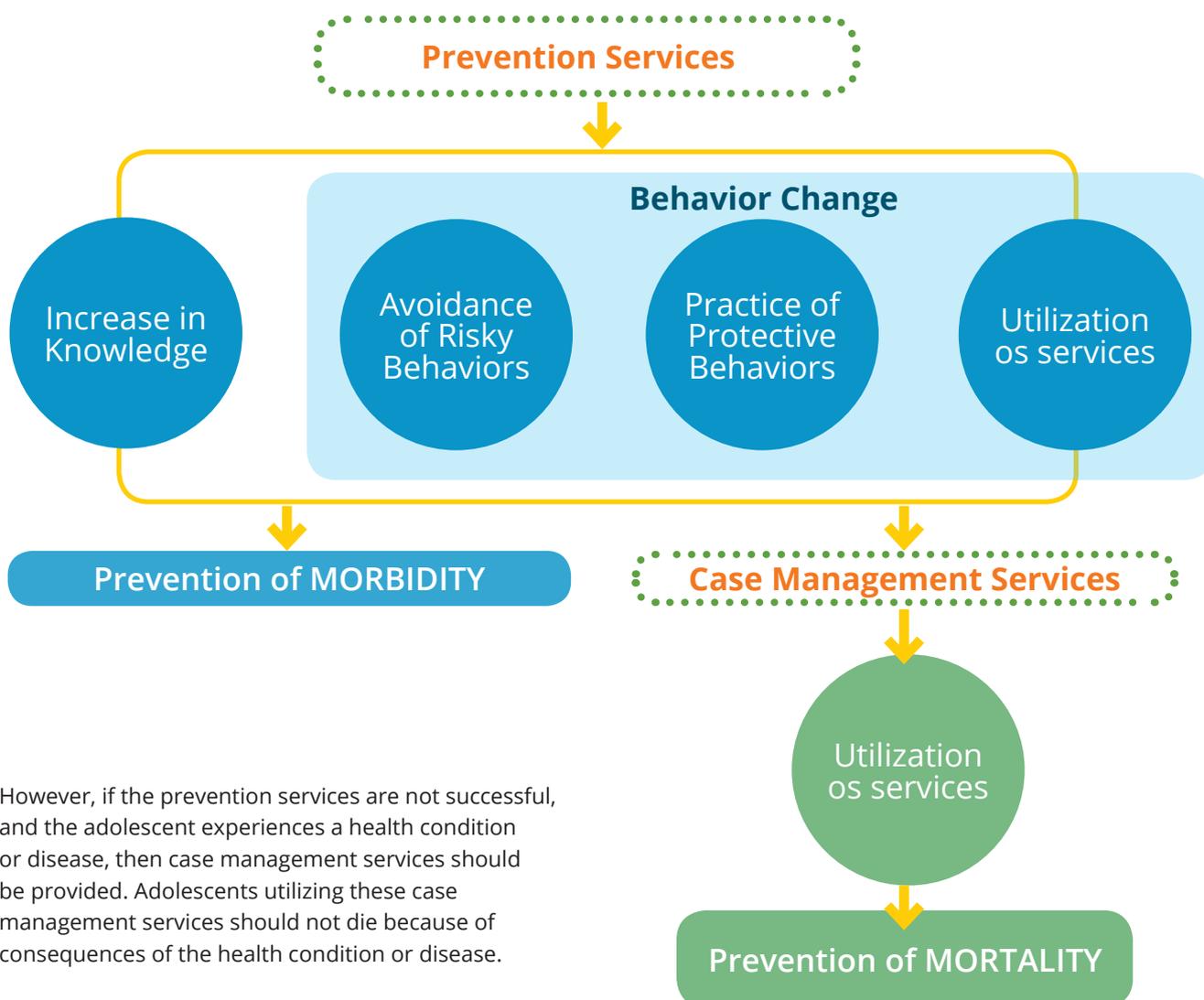
However, if the prevention services are not successful, and the adolescent experiences a health condition or disease, then case management services should be provided. Adolescents utilizing these case management services should not die because of consequences of the health condition or disease.

This is the logical framework that the AHDP follows. Ultimately, morbidities and mortalities will be prevented by providing the appropriate prevention and case management services to adolescents.

2.3. Adolescent Health and Development Program Components

In 2016, the AHDP together with DOH – Epidemiology Bureau, and members of both the external and internal Technical Working Groups decided to broaden their scope of interventions to ensure that they offer comprehensive, and integrated health services to adolescents. Nonetheless, some DOH programs that cater to adolescents continue to have their own initiatives but with coordination with AHDP program manager that focus on a narrow set of health indicators on 10 – 19 years old.

The AHDP manager together with other program managers are now operating within the facets of adolescent health and development that include the following Program Components:

- Nutrition
- Oral Health
- Vaccine Preventable Diseases
- Injuries
- Violence
- Mental Health
- Sexual and Reproductive Health
    - Family Planning
    - Safe Motherhood
    - HIV and STI
- Substance Abuse
    - Drugs
    - Alcohol
    - Tobacco Use

The effort to integrate adolescent health and development into health services may depend in part on how well the agency or organization has managed to provide clients with integrated care in other areas. If ante-natal care providers do not see the need to consider STI and HIV prevention in their services, then it may be even tough to encourage programmers or health care providers to recognize the relevance of integration of the program components. On the other hand, providers working in health programs that have already taken a more integrated approach to adolescent health have an increased potential to learning and value the importance of integrated   care on the adolescent related concerns.

Adolescent Health

- Nutrition
- Sexual and Reproductive Health
- Safe Motherhood
- Family Planning
- Vaccine Preventable Diseases
- Oral Health
- Substance Abuse
- HIV and STI
- Violence
- Drugs
- Injuries
- Mental Health
- Alcohol
- Tobacco Use

Adolescent Health and Development Program
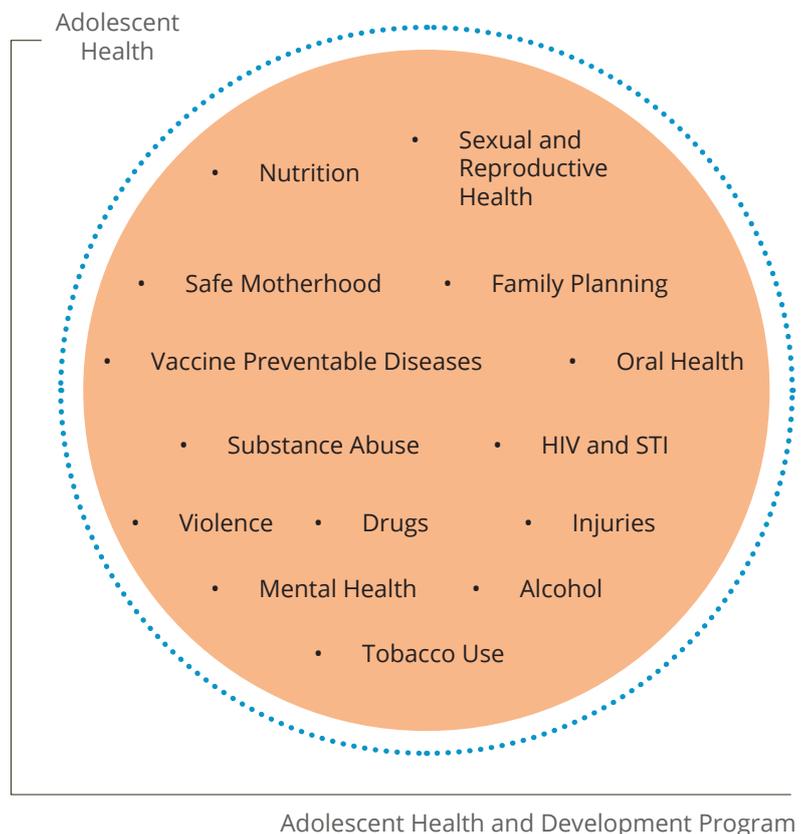
2.4 Adolescence with the Life-Stage approach

Health is indivisible and should be maintained across the life cycle or life-course. During infancy, childhood, adolescence, adulthood and advanced age, we are faced with different sets of risks on health and opportunities. As we get older, our roles change within families and communities. One of the key thrusts of the Philippine Health Agenda 2016-2022 is the provision of health guarantees - or services that keep Filipinos healthy throughout their life course and protect them from the triple burden of diseases. These guarantees are tangible manifestation of every Filipino's right to health.

The Philippine Health Agenda 2016-2022 also promises to transform the country's health system into a primary health care-driven system where the value of prevention and promotion, as well as appropriate referral (and/or gatekeeping) is emphasized. It is therefore a priority to identify these primary care services.

FIGURE 14. Life – Stage Approach

| Pregnant | Newborn | Infant | Child | Adolescent | Adults | Elderly |
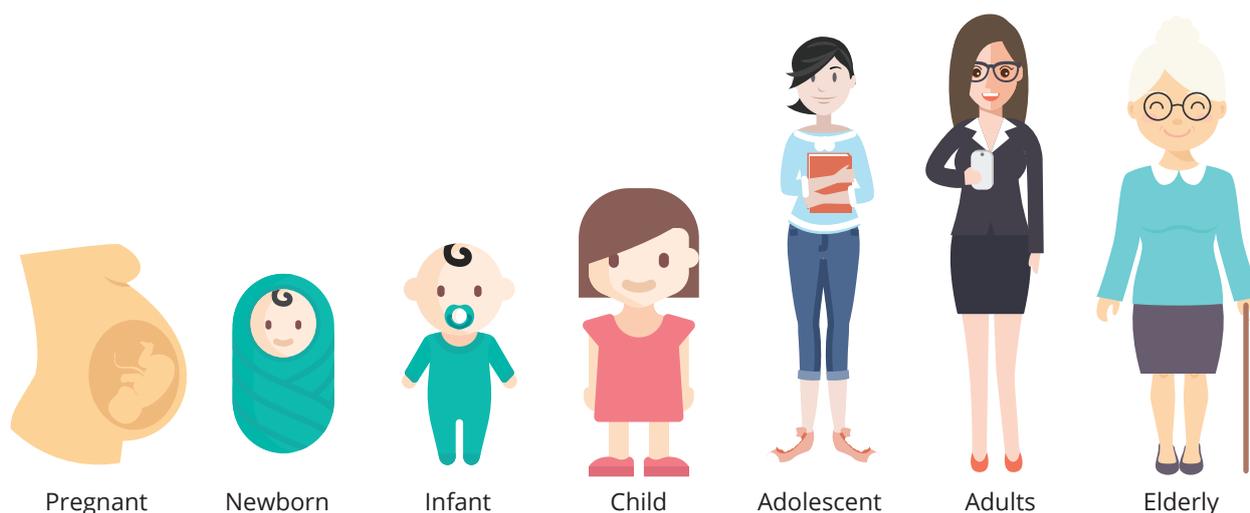
The life stage approach can also be used as a guide to better value the uniqueness of the adolescent health and development programming. Innovations in data collection reveal how the risks of situations, the challenges of accessing services and the solutions to these challenges change at different stages of life, and most important to note that it is evolving within adolescent age group.

Immunizations are continued from childhood to adolescence. Healthy habits, such as nutrition and physical activity, should be established and reinforced in childhood and adolescence to prevent lifestyle-related diseases in adulthood. Maternal health care – nutrition, iron and folic acid supplementation, measles, rubella, tetanus and hepatitis B immunizations, and family planning – should begin in adolescence before the woman gets pregnant. Behaviors and factors established at one point in the life-cycle affects the health outcomes in another point of the life cycle. Thus, the AHDP is part of the continuum of health programs from birth to ageing, and programmers must consider it since the beginning of the cycle.

2.5 Laws and Policies on the Rights and Responsibilities of Adolescents

The Philippines have signed international laws, policies, and agreements' recognizing adolescent health and development is a human rights. However, there is still much work to be done to ensure that these international agreements are put into practice. In reality in our society we have cultural traditions and norms that tolerate or justify violence, bullying, stigma and discrimination against adolescents. That is why, it is important to take into consideration the value of human rights in the implementation of the program.

Relevant International and National Laws and Policies on Adolescent Health and Development

Convention on the Rights of the Child

The Convention on the Rights of the Child, ratified on 02 September 1990, believes that parents or other persons legally responsible for the child need to fulfil with care their right and responsibility to provide direction and guidance to their adolescent children in the exercise by the latter of their rights. They have an obligation to take into account the adolescents' views, in accordance with their age and maturity, and to provide a safe and supportive environment in which the adolescent can develop.

Adolescents need to be recognized by the members of their family environment as active rights holders who have the capacity to become full and responsible citizens, given the proper guidance and direction. Before parents give their consent, adolescents need to have a chance to express their views freely and their views should be given due weight, in accordance with article 12 of the Convention. However, if the adolescent is of sufficient maturity, informed consent shall be obtained from the adolescent her/himself, while informing the parents if that is in the best interest of the child (art.3).

Rights and Responsibilities of Adolescents under Convention of the Rights of the Child

Rights of Adolescents

As you involve adolescents, particularly children below 18 years old, in program development, you are obliged to recognize and respect their rights. In General Comment No. 4 (2003), the Committee on the Rights of the Child discussed Adolescent health and development in the context of the Convention on the Rights of the Child. They mention the following rights:

- Right to health and development by creating a safe and supportive environment, which entails addressing attitudes and actions of both the immediate environment of the adolescent - family, peers, schools and services - as well as the wider environment created by, inter alia, community and religious leaders, the media, national and local policies and legislation. It is dependent on the development of youth-sensitive health care, which respects confidentiality and privacy and includes appropriate sexual and reproductive health services.
- Right to non-discrimination, including with regard to race, color, sex, language, religion, political or other opinion, national, ethnic or social origin, property, disability, birth or other status. These grounds also cover adolescents' sexual orientation and health status (including HIV/AIDS and mental health).
- Right to express views freely and have them duly taken into account
- Right to access information and material from a diversity of national and international sources, especially those aimed at the promotion of his or her social, spiritual and moral well-being and physical and mental health
- Right to privacy and confidentiality, including with respect to advice and counseling on health matters
- Protection from all forms of abuse, neglect, violence and exploitation
- Right to quality education
- Protection from early marriage and pregnancy, which are significant factors in health problems related to sexual and reproductive health, including HIV/AIDS
- Protection from violence. Vulnerable adolescents, such as those who are homeless or who are living in institutions, who belong to gangs or who have been recruited as child soldiers, are especially exposed to both institutional (schools, institutions for disabled adolescents, juvenile reformatories, etc.) and interpersonal violence.

Responsibilities of Adolescents

Everybody has rights. This means that everybody, including children, should respect the rights of others; however, related to the rights are responsibilities that each child, including adolescents should take upon themselves to comply with or to observe.

The following are some suggestions by UNICEF of the responsibilities that could accompany the rights of the CRC29.

- If every child has rights, then they also have a responsibility to respect the rights of others, including other children and their parents.
- If all children have a right to be protected from conflict, cruelty, exploitation and neglect, then they also have the responsibility not to bully or harm other children.
- If all children have the right to a clean environment, then they also have a responsibility to help look after their environment.
- If all children have a right to be educated, then they should learn as much as they are able to and, if possible, share their knowledge with others.
- If all children have a right to a full life, then they should also help ensure that the needy, the disadvantaged and victims of discrimination also enjoy this right.

International Conference on Population and Development (ICDP, 1994), Chapter VI, B. 6.15 states that the "youth should be actively involved in planning, implementation, and evaluation of development activities that have a direct impact on their daily lives. This is especially important with respect to information, education and communication activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV and other sexually transmitted diseases."

Universal Health Coverage (UHC) AHDP is part of universal health coverage (UHC), which means that all people receive the health services they need without suffering financial hardship when paying for them. The full spectrum of essential, quality health services should be covered including health promotion, prevention and treatment, rehabilitation and palliative care. On 12 December 2012, the United Nations (UN) General Assembly unanimously adopted a resolution on UHC, urging governments to move towards providing all people with access to affordable, quality health-care services.

Sustainable Development Goals (SDG) For the first time, adolescents join women and children at the heart of the UN Global Strategy for Women's, Children's and Adolescents' 2016-2030. This acknowledges not only the unique health challenges facing young people, but also their pivotal role alongside women and children as key drivers of change in the post-2015, Sustainable Development Goals (SDG) era. By investing in the right policies and programs for adolescents to realize their potential and their human rights to health, education and full participation in society, we can unleash the vast human potential of this SDG Generation to transform our world.

Memorandum Circular 2004-152 Guide to Local Government Units in the Localization of the Millennium Development Goals On 10 November 2004, the Department of the Interior and Local Government (DILG) issued Memorandum Circular 2004-152 Guide to Local Government Units in the Localization of the Millennium Development Goals. Adolescent Reproductive Health is one of the elements under Goal 5 Improved Women's Reproductive Health. Specifically, the memo instructs LGUs;

- to conduct massive education on fertility, responsible sexuality and health development including health lifestyle through formal education or outreach activity for young people,
- to educate parents on fertility, sexuality and RH and mobilize them for the provision of information to young people, and;
- To provide health services and counseling.

Republic Act 8504 On February 13, 1998, the Philippine Congress adopted and signed into law a HIV-specific legislation that provided the national policy on HIV prevention, control, care and support. This is Republic Act No. 8504, otherwise known as the "Philippine AIDS Prevention and Control Act of 1998". This legislation contains the definitive State Policies on HIV/AIDS on concerns affecting Testing, Screening, and Counseling; Monitoring; and, Confidentiality.

Republic Act 8371 Pursuant to Section 80 of Republic Act No. 8371, otherwise known as "The Indigenous Peoples' Rights Act of 1997" (IPRA). The National Commission on Indigenous Peoples (NCIP) in consultation with indigenous peoples shall assess the situation of children and youth both in rural areas and highly urbanized centres with regards to the recognition, promotion and protection of their rights as provided in the Act and the Universal Declaration on the Rights of the Child.

Republic Act 9442 an Act Amending Republic Act No. 7277, Otherwise known as the Magnat Carta for Persons with Disability as Amended, and for other purposes' Granting Additional Privileges and Incentives and Prohibitions on Verbal, Non – Verbal Ridicule, and Vilification Against Persons with Disability.

Republic Act 9165 an Act Instituting the Comprehensive Dangerous Drugs Act of 2002. It is the policy of the State to safeguard the integrity of its territory and the well-being of its citizenry particularly the youth, from the harmful effects of dangerous drugs on their physical and mental well-being, and to defend the same against acts or omissions detrimental to their development and preservation. In view of the foregoing, the State needs to enhance further the efficacy of the law against dangerous drugs, it being one of today's more serious social ills.

Republic Act 7610 "Special Protection of Children Against Abuse, Exploitation and Discrimination Act." It is hereby declared to be the policy of the State to provide special protection to children from all firms of abuse, neglect, cruelty exploitation and discrimination and other conditions, prejudicial their development; provide sanctions for their commission and carry out a program for prevention and deterrence of and crisis intervention in situations of child abuse, exploitation and discrimination. The State shall intervene on behalf of the child when the parent, guardian, teacher or person having care or custody of the child fails or is unable to protect the child against abuse, exploitation and discrimination or when such acts against the child are committed by the said parent, guardian, teacher or person having care and custody of the same.

RA 10354 or the Responsible Parenthood and Reproductive Health (RPRH) Law On 21 December 2012, the Philippines enacted the RA 10354 or the Responsible Parenthood and Reproductive Health (RPRH) Law. On April 2014, the Supreme Court upheld the constitutionality of RA 10354. However, the SC also struck down several provisions, including that of providing, without parental consent, contraceptives for minors who have given birth or have had a miscarriage, among other provisions.

IRR of RA 10354, Section 4.07 Access of Minors to Family Planning Services
Any minor who consults at health **care facilities shall be given age-appropriate counseling on responsible parenthood and reproductive health.**
Health care facilities shall dispense health products and perform procedures for family planning
provided
that in public health facilities, any of the following conditions are met:
(a) The minor presents written consent from a parent or guardian.

Comprehensive Sexuality Education The RPRH Law (2012) also provides for Age- and Development-Appropriate Reproductive Health Education wherein the State shall provide age- and development-appropriate reproductive health education to adolescents which shall be taught by adequately trained teachers informal and non-formal educational system and integrated in relevant subjects such as, but not limited to, values formation; knowledge and skills in self-protection against discrimination; sexual abuse and violence against women and children and other forms of gender based violence and teen pregnancy; physical, social and emotional changes in adolescents; women's rights and children's rights; responsible teenagebehavior; gender and development; and responsible parenthood: Provided, that flexibility in the formulation and adoption of appropriate course content, scope and methodology in each educational level or group shall be allowed only after consultations with parents-teachers-community associations, school officials and other interest groups. The Department of Education (DepEd) shall formulate a curriculum, which shall be used by public schools and may be adopted by private schools.

2.6 Gender and Sexual Orientation and Gender Identity and Expression (SOGIE)

Gender analysis is a systematic analytical process used to identify, understand, and describe gender differences and the relevance of gender roles and power dynamics in a specific context. Such analysis typically involves examining the differential impact of development policies and programs on women, men, lesbian, gay, bisexual and transgender (LGBT) adolescents. This necessitates the collection of sex-disaggregated or gender-sensitive data.

Definitions of Sexual Orientation and Gender Identity and Expression

Sexual orientation

refers to a person's physical, romantic, and/or emotional attraction towards other people. Sexual orientation is distinct from gender identity. Sexual orientation is comprised of three elements: sexual attraction, sexual behaviour, and sexual identity. Sexual orientation is most often defined in terms of heterosexuality to identify those who are attracted to individuals of a different sex from themselves, and homosexuality to identify those who are attracted to individuals of the same sex from themselves.

Gender Identity

is understood to refer to each person's deeply felt internal and individual experience of gender, which may or may not correspond with the sex assigned at birth, including the personal sense of the body (which may involve, if freely chosen, modification of bodily appearance or function by medical, surgical or other means) and other expressions of gender, including dress, speech, and mannerisms. Gender identity exists on a spectrum. This means that an individual's gender identity is not necessarily confined to an identity that is completely male or completely female. When an individual's gender identity differs from their assigned sex, they are commonly considered to be transgender, gender fluid, and/or gender queer. Whereas when an individual's gender identity aligns with their assigned sex, they are commonly considered cis gender.

Gender Expression

refers to the way in which an individual outwardly presents their gender. These expressions of gender are typically through the way one chooses to dress, speak, or generally conduct themselves socially. Our perceptions of gender typically align with the socially constructed binary of masculine and feminine forms of expression. The way an individual expresses their gender is not always indicative of their gender identity.
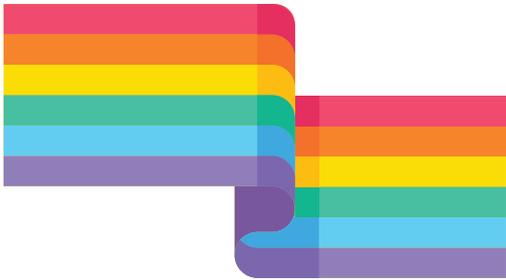
Lesbian, Gay, Bisexual, Transgender (LGBT) Adolescents

Another issue is the stigmatization and exploitation of lesbian, gay, bisexual, transgender (LGBT) adolescents. They are at particular risk for violence and discrimination. LGBT youth experience bullying, discrimination, isolation,and rejection from their families. LGBT youth rejected by families experience disproportionate levels of suicide, homelessness and food insecurity. Discrimination and violence contribute to the marginalization of LGBT people and their vulnerability to ill health including HIV infection, yet they face denial of care, discriminatory attitudes in medical and other settings.

Programs should maintain that human rights are universal – cultural, religious and moral practices and beliefs and social attitudes cannot be invoked to justify human rights violations against any group, including LGBT persons. Therefore, we should protect them from violence, torture and ill treatment by:

- Investigating, prosecuting and providing remedy for acts of violence, torture and ill-treatment against LGBT adults, adolescents and children, and those who defend their human rights,
- Strengthening efforts to prevent, monitor and report such violence,
- Incorporating homophobia and transphobia as aggravating factors in laws against hate crime and hate speech, and;
- Develop non-discriminatory attitudes among health service providers, as part of adolescent-friendly services.
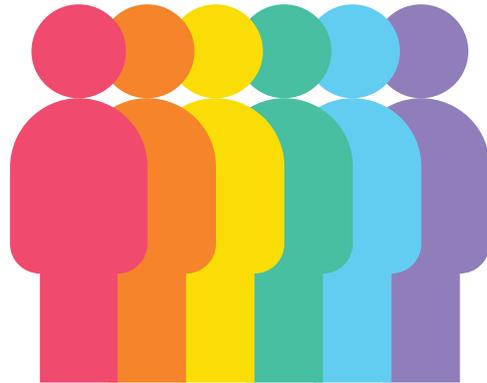
Women, Girls, Boys, and LGBTQ

Gender analysis examines the different roles, rights, and opportunities of men and women and relations between them. It also identifies disparities, examines why such disparities exist, determines whether they are a potential impediment to achieving results, and looks at how they can be addressed. The principle of non-discrimination seeks to guarantee that human rights are exercised without discrimination of any kind based on race, color, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation.

Questions to ask include:

1. How will the different roles and status of women/girls, men/boys, and LGBTQ within the community, political sphere, workplace, and household (for example, roles in decision making and different access to and control over resources and services) affect the work to be undertaken?

2. How will the anticipated results of the work affect girls, boys, and LGBTQ differently?

An example of this issue is the double standard where girls are discouraged from engaging in sexual activities while tolerated and even encouraged among boys.

Program Development and Management

3.1 Meaningful Participation of Adolescents

The United Nations Committee on the Rights of the Child (2009) defines participation as ongoing processes, which include information-sharing and dialogue between children and adults based on mutual respect, and in which children can learn how their views and those of adults are taken into account and shaped the outcome of such processes.

The United Nations defines youth participation as, the United Nations defines youth participation using and dialogue between children and adults based on mutual respect, and in which child empowerment to contribute to decisions about their personal, family, social, economic and political development".

Adolescents provide an essential voice to the AHDP. They are highly creative and passionate about the issues that matter to them. They bring ideas that come from their unique experience and enable the adults to see the program from the eyes of its target population.

Adolescents shall be involved throughout the program development cycle, starting with analysing the situation. This not only benefits the adolescent, but also helps you attain your program goal. Studies show, for example, that having adolescents participate in certain aspects of program management, such as in the technical working group or quality improvement team, helps sustain behaviour change.

In public health, adolescent participation can take a number of different forms including:

- **Informing** adolescents with balanced, objective information.
- **Consulting**, whereby an adult-initiated, adult-led and adult-managed process seeks adolescents' expertise and perspectives in order to inform adult decision-making. (Sample case study in Annex)
- **Involving**, or working directly with, adolescents in the communities. (Sample case study in Annex)
- **Collaborating** by partnering with affected adolescents in communities in each aspect of a decision, including the development of alternatives and identification of solutions. (Sample case study in Annex)
- **Empowering**, by ensuring that adolescents in communities retain ultimate control over the key decisions that affect their well-being. This translates into adolescent-led participation where adolescents are afforded, or claim, the space and opportunity to initiate activities and advocate for themselves. (Sample case study in Annex)

It is important, however, to ensure that adolescents are protected as they participate in program development and implementation. The Inter-agency Working Group on Children's Participation prescribes Minimum Standards for Consulting with Children, which describe what agencies need to do to ensure that children participate meaningfully in a formal consultation. These are based on the following principles:

- Transparency, honesty and accountability. Adults involved in consultations with children follow ethical and participatory practice and put children's best interests first.
- A children-friendly environment. Children experience a safe, welcoming, inclusive and encouraging environment that enables participation.
- Equality of opportunity. Participatory work shall include groups of children who typically suffer discrimination or who are often excluded from activities, such as working children, children with disabilities and children from indigenous communities.
- Safety and protection of children. Involvement in a consultation must not expose any young person to threats or actual harm to well-being. A child's safety and health is considered in every possible way, with safeguards put in place. This includes both physical and emotional well-being.
- Commitment and competency of adults. Adults working with children are committed to the aim of consulting with children and are trained and supported to carry out participatory practices

3.2 Meaningful Involvement of Parents and the Community

Involve the Parents

Safe and supportive families are crucial to helping young people develop to their full potential and attain the best health in the transition to adulthood. There is increasing evidence that parenting behaviours predict positive outcomes. Parents who are highly knowledgeable about their child's activities have adolescents who are less likely to engage in problem behaviours. Parents own behaviours can also influence adolescent health and behaviour directly through modelling. Therefore, parents shall also be capacitated to provide positive monitoring, two-way communication and support. Sample case study in Annex describes Parenting Education Sessions that are conducted by the Department of Social Welfare and Development (DSWD) and Commission on Population (POPCOM).

The CRC also acknowledges the responsibilities, rights and duties of parents (or other persons legally responsible for the child) to provide, in a manner consistent with the evolving capacities of the child, appropriate direction and guidance in the exercise by the child of the rights recognized in the Convention.

In planning, make the effort to involve both mothers and fathers or guardians. Studies show that they have different relationships with their adolescent child. Also, get input from secondary caregivers (grandparents, older siblings, aunts/uncles) who care for the adolescent when their parents are away.

Involve the Community

The community is anyone outside the home and the health system that influence the wellbeing of the adolescent. They could be barangay or neighbourhood associations, schools, barangay councils, tanods, indigenous people's leaders, civil society organizations, women's groups, community health teams, and barangay health workers.

The community helps create a safe and supportive environment for adolescents as the influence of factors outside the family increases during adolescence. For example, exposure to violent and sexualized content linked with advertising for cigarettes and alcohol has been shown to increase problems of violence, cigarette and alcohol use, and early initiation of sexual behaviour in susceptible adolescents.[1] Policies and their enforcement often rest on the barangay, e.g. anti-vagrancy and anti-smoking ordinances, curfew, and reporting of abuse. Schools are important because educational involvement and attainment, starting from early life, is linked to later health outcomes. Thus, it is important to involve the various sectors in the larger community. Program Development and Management will provide various steps on how to meaningfully involve adolescents, parents, and the community in the program implementation.

3.2 Program Development and Management

As you design your own adolescent health and development program (AHDP), it is important to be deliberate and strategize, anchoring program decisions on evidence and input from various stakeholders, including adolescents, parents, and community leaders. This manual breaks down the process into seven steps, as illustrated in Figure 15:

Step 1: Organize a **multi-sectoral team** that will work on the planning and implementation of your AHDP.

Step 2: Analyse the situation, gathering quantitative and qualitative data on the health status and other issues of adolescents in your area and mapping where you can find adolescents, services and resources. This data will help you decide which issues to prioritize in your program.

Step 3: Come up with **health and behavioural objectives.**

Step 4: The **strategies** you select will depend upon this behavioural analysis.

Step 5: So, too, will the **activities** that you will implement.

Step 6: Now comes **implementing and monitoring** your program.

Step 7: Then it will be time to **assess and evaluate**, then go back to analysing the situation, and if needed, re-thinking your objectives, behavioural analysis, strategies and so on.

FIGURE 15. Adolescent Program Development and Management Cycle
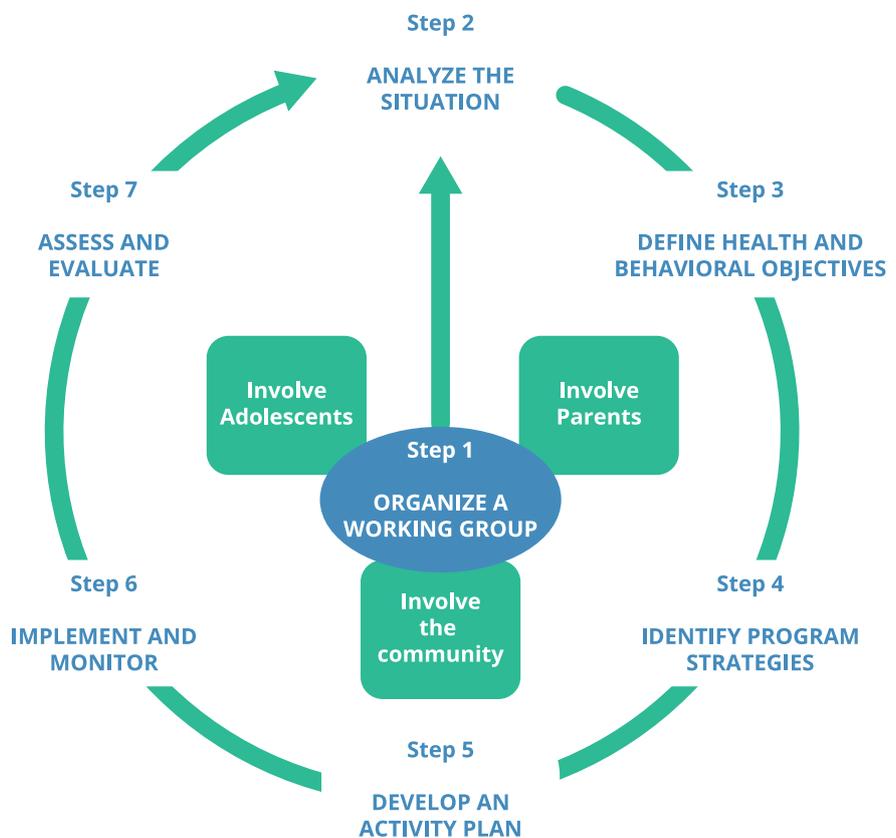
Results chain

The Program Development Cycle is based on the Results Chain framework. Each step shall be based on the product of the previous step. Moving backward in the program cycle, the inputs and activities shall achieve the chosen outputs, which, in turn shall result in the identified outcomes, which lead to the common goals of improving the health status of adolescents and ensuring they all enjoy their right health. Table 1 defines and gives an example of this chain of results. As you move through the process of program development, you will be able to determine each column of the results chain.

TABLE 1. Results Chain

Inputs	Major Activities	Outputs/Strategies	Outcomes	Goal
Resources -- human resource, funds, technical assistance and other types of resources are mobilized in activities to produce specific outputs	Actions taken or work performed through which inputs, such as funds, technical assistance and other types of resources are mobilized to produce specific outputs.	The changes in skills or abilities, or the availability of new products and services that result from the completion of activities within a development intervention	The institutional and behavioral changes in development conditions that occur between the completion of outputs and the achievement of goals. They are the intended or achieved effects of an intervention's outputs, usually requiring the collective effort of partners.	Positive and negative long-term effects on identifiable population groups produced by a development intervention, directly or indirectly, intended or unintended. These effects can be economic, socio-cultural, institutional, environmental, technological or of other types.

Results Chain Example				
Inputs	**Major Activities**	**Outputs/ Strategies**	**Outcomes**	**Goal**
Manpower from health centre	School-to-school campaign promoting physical activity	Health Promotion and Behavior Change	Physical activity among adolescents is increased	Improved health status of adolescents Adolescents fully enjoy their right to health
Health promo materials	Quality improvement to make facilities adolescent-friendly Advocate for access to school covered court after school hours and during weekends and holidays	Improving access to quality and adolescent-friendly health care services and information for adolescents		
Quality improvement team	Advocate for access to school covered court after school hours and during weekends and holidays	Improving access to quality and adolescent-friendly health care services and information for adolescents		
Support from school authorities	Quality improvement to make facilities adolescent-friendly			
Advocate for access to school covered court after school hours and during weekends and holidays	Improving access to quality and adolescent-friendly health care services and information for adolescents			

Gathering support

Before you begin the process of developing your adolescent health and development program, it is important to get the support of the head of your agency or organization. In the local government context, this also means getting the support of the local chief executive and local legislative council. Let them know why you are undertaking this process, i.e. being more strategic about providing services and interventions for adolescents to be more effective and to maximize resources. This early advocacy will make it easier for you to obtain the resources you need to complete the process as well as to implement your program.

The Family Planning Organization of the Philippines (Health Care Provider) had a meeting with the Governor of Antique, Regional DOH Officer, and Public Health Officer of the Province of Antique.

Stakeholder participation

Your program will be more sustainable when there is ownership of all stakeholders. In every step, it is important to involve adolescents, their parents, and the rest of the community to ensure that their views are being heard and their rights respected. They are also an excellent source of information as you plan then implement your program, but keep in mind that adults need to be capacitated to create and enabling environment for adolescents to participate. Table 3 below and the succeeding paragraphs describe how adolescents, their parents, and the community can be involved at each step of the program development cycle.

TABLE 3 . Involvement in Program Development

Step	How do you involve?		
	Adolescents	Parents	Community
1. Organize a team	Include members of student government, school organizations, out-of-school youth, gangs, and other adolescent-led groups	Consider including members of parents' groups, PTCA, barangay leaders, , school guidance counsellors, clinic teachers, barangay councils, tanods, indigenous people's leaders, civil society organizations, women's groups, community health teams, barangay health workers, person with disabilities and other barangay or neighbourhood associations	
2. Analyze the situation	Ask them to help collect information Conduct activities to gather their views on the issues facing adolescents in their community Guide them in understanding what the information they gathered means	Ask them to help collect information Conduct activities to gather their views on the issues facing adolescents in their community	Ask them to help collect information Conduct activities to gather their views on the issues facing adolescents in their community
3. Define health status & behavioral objectives	Incorporate their views in the criteria for selection of priority outcomes	Incorporate their views in the criteria for selection of priority outcomes	Incorporate their views in the criteria for selection of priority outcomes
4. Identify program strategies	Ask them to participate in meetings to formulate program strategies and plans	Ask them to participate in meetings to formulate program strategies and plans	Ask them to participate in meetings to formulate program strategies and plans
5. Develop an activity plan			
6. Implement and monitor	Ask them how they think monitoring shall be done Ask for their views on how the program is working so far	Ask for their views on how the program is working so far	Ask for their views on how the program is working so far
7. Assess and evaluate	Ask for their views on the impact and effectiveness of the program Guide them in the analysis and implications to the program	Ask for their views on the impact and effectiveness of the program	Ask for their views on the impact and effectiveness of the program

Program Development and Management

Step 1: Organize a working group

The objective of this step is to organize a multi-sectoral working group for the development of your local AHDP.

In this step, ask:

- What is the function or scope of work of our technical working group? Teams can be formed for program design, implementation, and/or monitoring. The function may change as you progress along the program cycle.
- Who will be the members of our team? The municipal health officer, schools division supervisor, social welfare, or planning officers can be members. Don't forget to include officers of adolescent organizations.
- How will we involve adolescents?
- How will we involve parents?
- How will we involve the community?
- What will be the roles of each TWG member? Usually, the representative of the health office is the focal point. Some members may be there just to provide data. Some may have access to funding or are decision makers in the LGU planning process.
- What resources and strengths do we have as a team? Some TWG members may already have programs being implemented. There may be a strong LGU-NGO partnership.
- What gaps and weaknesses do we have as a team? Perhaps there is no one who can provide the data you need. Your Local Council for the Protection of Children or Local Health Board may not be functional.
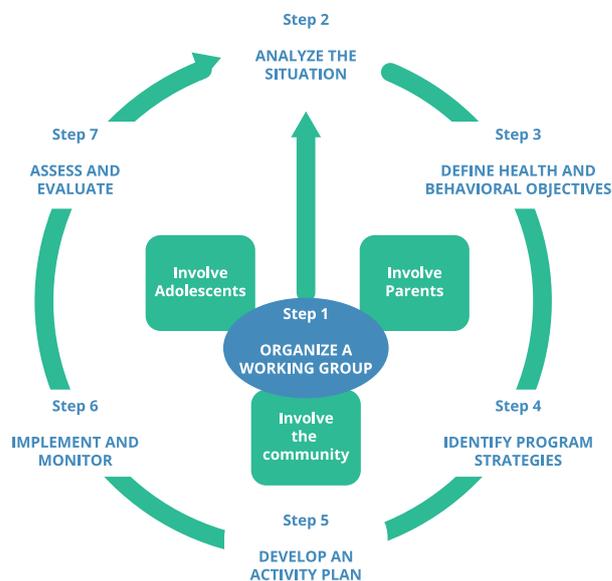
A broad range of agencies and organizations is necessary because adolescent health is affected by many issues other than health and addressing these calls for a concerted effort across sectors. Therefore your first step is to assemble a multi-sectoral working group for the development of your local adolescent health and development program. The group should include several adolescents and community leaders. This group will be your adolescent health and development TWG. The team may include – but is not limited to – the adolescent health and development point persons from the local Health Office, Social Welfare, Education (division head, principal, school nurse or clinic teacher), Planning, local legislative bodies, hospitals, pharmacies, private health providers, civil society, faith-based or religious groups, and community based organizations working with adolescents, and several trained peer educators or members of local adolescent organizations. There should be enough adolescents so they are comfortable discussing their views with the adults. All members of the working group should have or be capacitated with a basic knowledge of the issues facing adolescents and on the ground realities.

Team composition can be based on AO 2013-0013, the DOH policy on Adolescent Health and Development, which lists the roles and responsibilities of the different sectors. Localizing these roles, the health department/office should lead the team and serve as the overall focal point.

- **Local Health Office (Rural Health Unit, City Health Offices/Departments)**

  A. Serve as the focal point for overall planning, management, monitoring, and evaluation of the AHDP
  B. Provide technical leadership in all matters pertaining the AHD
  C. Advocate for adolescent health and development in national and local public forums
  D. Ensure meaningful participation of adolescents at all stages of the program cycle
  E. Create, strengthen, and maintain inter-agency links and public-private partnerships
  F. Formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum With the DSWD, DepEd, CHED, and TESDA
  G. Provide parents with adequate and relevant scientific material on the age-appropriate topic and manner of teaching Reproductive Health and Sexuality Education to their children
  H. Provide age-disaggregated data necessary to for monitoring and evaluation of results of the AHDP
  I. Provide technical assistance and guideline in matters pertaining to STI and HIV and AIDS and services for Young Key Affected Populations

- **Regional Office - DOH**

  A. Localize and disseminate policies
  B. Provide technical assistance to local government units in implementation
  C. Monitor results and report these to the DOH Central Office
  D. Create inter-agency links to support local government units in implementation of the AHDP
  E. Advocate for policies and resources at the local level
  F. Assist devolved hospitals and health care facilities in meeting the National Standards for the Provision of Adolescent-Friendly Health Services

- **Department of Education (DepEd), Commission on Higher Education (CHED), and Technical Education and Skills Development Authority (TESDA)**

  A. Teach an age- and development-appropriate Reproductive Health and Sexuality Education curriculum, with the Social Welfare and Health Departments
  B. Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children
  C. Integrate other adolescent health concerns in school curriculum
  D. Mobilize teachers, guidance counselors, and parents to implement the AHDP

- **Local offices of the Department of Social Welfare and Development (DSWD), Commission on Population (POPCOM), National Anti-Poverty Commission (NAPC), National Youth Commission (NYC)**

  A. Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children
  B. Provide adolescent-friendly health services and protection to adolescents who are out of school with disabilities, in conflict with the law, drug dependent, on the streets, in prostitution, survivors of calamity, in situations of armed conflict, and survivors of abuse and exploitation
  C. Implement policies, programs and measures on adolescent participation
  D. Assist in monitoring and evaluation of results of the AHDP
  E. Create inter-agency links to build the support of local government units for the implementation of the AHDP
  F. Advocate, mobilize and generate resources for adolescent development

- **Philippine Statistics Authority**
  Provide age-disaggregated data necessary to for monitoring and evaluation of results of the AHDP

- **Philippine Health Insurance Corporation (Phil Health)**
  Provide benefits coverage for adolescents, particularly marginalized sub-sectors

- **Professional Medical and Allied Medical Associations**

  A. Develop members' capacity to provide adolescent-friendly health services
  B. Provide technical assistance in the formulation of policies, guidelines, and tools for adolescent health and development
  C. Contribute to research on adolescent health and development
  D. Advocate for adolescent rights as enshrined in the CRC
  E. Participate in the design and implementation of adolescent health and development programs
  F. Participate in the monitoring and evaluation of results of the AHDP Adolescent and Youth Organizations
  G. Develop members' capacity to advocate for and, in a manner appropriate for them, help manage adolescent-friendly health services
  H. Provide inputs in the formulation of policies, guidelines, and tools for adolescent health and development
  I. Participate in the design and implementation of adolescent health and development programs
  J. Participate in the monitoring and evaluation of results of the AHDP

- **Non-Government, Faith-based, Civil Society Organizations, the United Nations and other development partners working with and for adolescents**

  A. Implement adolescent-centered programs and outreach services in priority communities that are consistent with the AHDP in coordination with government agencies
  B. Provide technical assistance in the formulation of policies, guidelines, and tools for adolescent health and development
  C. Contribute to research on adolescent health and development
  D. Advocate, mobilize and generate resources for adolescent health and development

- **Private Sector**

  A. Enforce policies for the protection of adolescent employees
  B. Implement workplace programs for parents of adolescents

C. Support adolescent health and development activities in communities, schools, and other settings

- **Local Government Units**

  A. The provision of reproductive health information, care and supplies shall be the joint responsibility of the National Government and Local Government Units (LGUs).
  B. LGUs must ensure provision of basic adolescent health care services including, but not limited to, the operation and maintenance of facilities and equipment necessary for the delivery of a full range of reproductive health care services and the purchase and distribution of family planning goods and supplies as part of the essential information and service delivery package defined by DOH.
  C. LGUs, specifically the Rural Health Units, City Health Offices, and Provincial Health Offices, are responsible for designing, funding, implementing, and monitoring local Adolescent Health and Development programs suited for adolescents in their area, in partnership with youth, government agencies, civil society, and the private sector, under the technical guidance of the DOH Regional Office and AO 2013-0013. LGUs shall design specific strategies to reach marginalized and vulnerable adolescent sub-sectors. They shall ensure meaningful participation of adolescents and communities in this process. Hospitals and health care facilities under LGU management must meet the National Standards for the Provision of Adolescent-Friendly Health Services.

> **LGUs, specifically the rural health units, city health offices, and provincial health offices, are responsible for designing, funding, implementing, and monitoring local adolescent health and development programs suited for adolescents in their area, in partnership with youth, government agencies, civil society, and the private sector.**
> **(DOH A.O. 2013-0013)**

Forming the working group

Consider a quick stakeholder analysis in order to decide who to invite to the team. There could be a core team and an extended or support team.

Consider expected team members and their attributes when answering the following questions:

- Who is expected to participate? How many?
- What levels or positions do team members represent?
- What is the educational level? What is the language proficiency?
- Are they experienced in the topic and the process involved?
- Is there a desired mix of participants from different sectors?
- How are participants being selected?
- Are all critical stakeholders adequately represented and actively recruited?
- Are there potentially too many participants for the team's purpose and limitations?

Team members' expectation

- What are team members expecting from both the process and outcome of the process?
- Are team members' expectations realistic? Are there unrealistic expectations?

Team members' interest

- What are the general positions or agenda that individuals may bring to the process?
- Are there natural/logical groupings or work teams among the expected team members?
- In what ways are the expected team members similar or different?

Group dynamics and relations

- Are there potentially some group-dynamic issues? For example, dominating personalities, angry group members, etc.
- Are there political or status relationships to be considered?
- Will guests or observers be invited to some team meetings?

The working group may be formalized with a Memorandum of Agreement (MOA) or a Resolution. The MOA shall be clear on where accountability, operational control and supervision of the various agencies will rest. Even without a MOA, team members shall agree upon the specific objective of forming the team, its scope and limitations, ways of working, each member's roles and responsibilities, and reporting and data sharing protocols.

Choose to capitalize on existing groups who can take on the work of developing and managing your adolescent health and development program. An example is the Local Health Board, which is mandated to have representatives of various sectors. Another existing group could be the Local Council for the Protection of Children, which functions as the core local institution for child-related programs. Remember, however, that the LCPC mandate is only for children, i.e. below 18 years old, compared to the AHDP which serves the 18-19 age groups in addition. This issue might be addressed internally.

Having a multi-sectoral program team can facilitate your AHDP's integration into relevant programs, strategies, policies, and budgets such as the LGU planning cycle; Reproductive Health/ Family Planning (RH/FP), Maternal Newborn and Child Health and Nutrition (MNCHN), and HIV of the Health Department; and the Family Development, Youth Development, and Parent Education Sessions of the Social Welfare Department.

Step 2: Analyse the situation

The main objective of this step is to get a good picture of adolescents' needs and the issues surrounding their rights.

In this step, ask:

- What are the most immediate needs of adolescents in our area? Is it prevention of early pregnancy, drug abuse, or mental health?
- Who are the adolescents most vulnerable to risks? Where and how can we reach them? For example, LGBTQ are vulnerable to exploitation. They may be reached through their peers or in schools.

What data are available locally? You may be able to acquire data on population from your local civil registry. Health offices may have data on service utilization, but they might not be disaggregated by age.

All quality programs are based on a comprehensive situational analysis. You can start with quantitative data from your civil registry and health department. How many adolescents (10-19 years old) are in your area? You may further disaggregate into early (10-13), middle (14-16) and late (17-19) adolescents. Who are the most vulnerable among adolescents in your area? What are the most common causes of death and illness among adolescents in your city? What is your city's adolescent birth rate (number of live births to women 10-19 years old divided by the total population of women 10-19 years old)? What is the prevalence of risk behaviors (drugs, alcohol, smoking, unsafe sex, etc.) among adolescents in you city? What is the nutrition status (wasted, stunted, overweight/obese, micronutrient deficient) of adolescents in your city?

Some of these data may not be readily available, but don't let this stop you from proceeding with the program development process. You can do a rapid appraisal based on your team's own observations and experience gained through scanning your environment. You can also gather qualitative information through key individual interviews (KII) or focus group discussions (FGD). Consider a Participatory Rural Appraisal (PRA) approach, where adolescents, parents, and community members share information with you. This is could include methods such as semi-structured interviews, transect walks (systematically walking with informants through an area, observing, asking, and listening), case stories, and participatory diagramming. One participatory diagramming method, community mapping, is described below.

Community mapping

In separate groups, ask adolescents and parents/ the community to draw a rough map of their area. It would be good to separate the young people from the older adults so their unique perspectives will surface. Each group shall have their own map containing the following information:

- Where can you find adolescents? Where can you find adolescents living in extreme poverty, street children, out-of-school adolescents, indigenous peoples, children in conflict with the law, displaced adolescents, adolescents with disability and other vulnerable groups? These are commonly in malls, basketball courts, internet cafés, streets, and schools.
- What are their main activities and where do they do these? For example, basketball or computer games.
- Where are the schools, malls, internet cafes, and other places they congregate?
- Where do they engage in risk behaviors (drugs, drinking, smoking, unprotected sex)? Risk behaviors are often in friends' houses, motels, bars, or vacant lots.
- What services are available to them and where can they find these? Where are the health centers, hospitals, NGOs, and private facilities?

FIGURE 16. Sample Community Mapping (Youth and Adult)
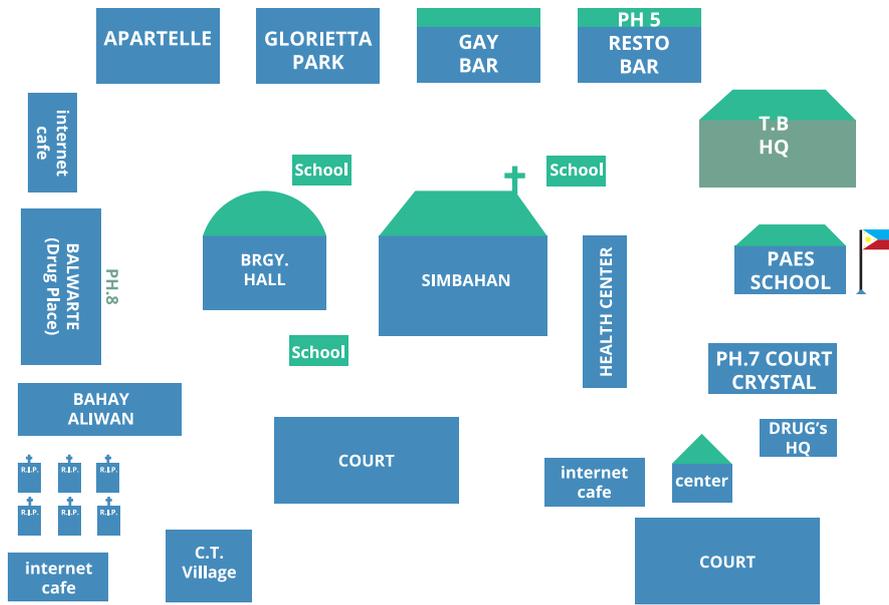
Note the similarities and differences between the map of young people and those of the older adults. Combine the information on both maps.
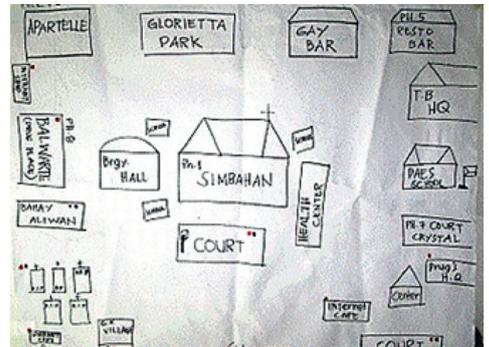
Made by young people
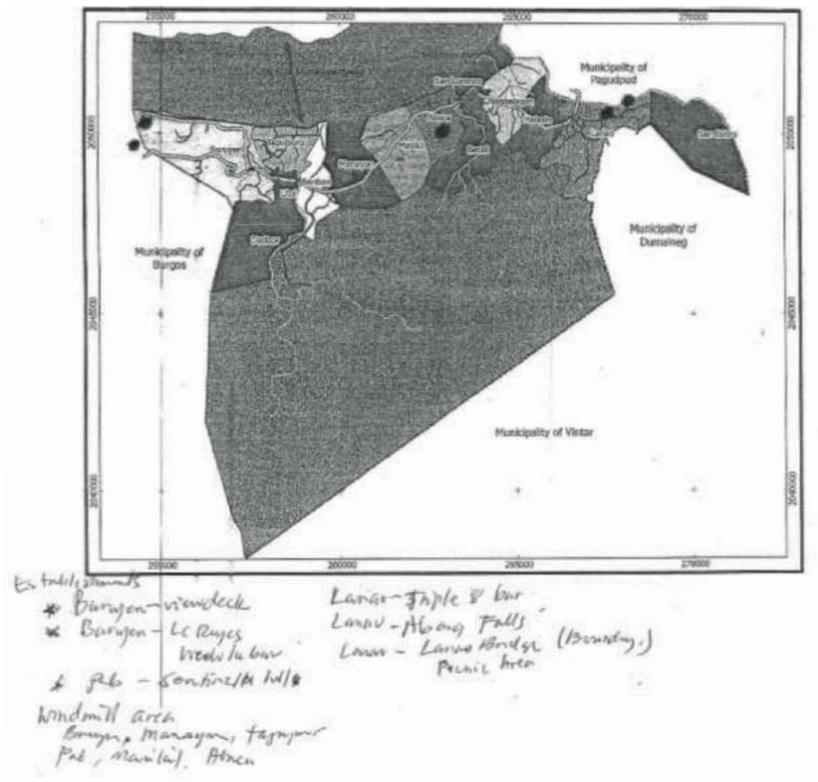
Made by older adults

Step 3: Define health status and behavioural objectives

The main objective of this step is to decide on the priority issues and behaviour, as identified in Step 2 to include in your program and formulate objectives for addressing these issues and behaviors.

In this step, ask:

- How many health problems can we take on, given our resources? You shall balance need and what resources you can mobilize.
- What health issues shall be addressed by our AHDP?
- What positive and negative behaviors affect these health issues? How do we measure behaviors?

Adolescents face a multitude of risks and mitigating these call for interventions that address more than one issue. It is accepted that actions shall be taken on all of these issues. However, resources are often limited. Thus, you need to decide what the most immediate needs of adolescents are in your locality. The emphasis given to each outcome, and the specific problems under each outcome, will vary from one place to another. Perceptions of adolescents or of community leaders shall factor into this decision. Just as importantly, your decision shall be backed by the evidence you gathered during your situational analysis.

How do we prioritize health outcomes for adolescent program?

Worksheet 1 on Prioritize health outcomes is an option of how you might choose between various general health outcomes and specific health problems to arrive at priorities for your adolescent program. The worksheet lists general health outcomes. Under each health outcome, you shall list specific health problems prevalent in your community. Agree on the criteria and scoring system, utilizing the suggested, or developing your own, criteria. In Sample Worksheet 1, magnitude of the problem pertains to how many adolescents are affected by the issue or the prevalence of the disease or behaviour. The higher the score, the more widespread the issue. Importance pertains to how adolescents and the larger community view the issue. A higher score means they see it as a major problem. Come up with your own criteria for selection.

Then, proceed to assign a score on each criterion for each health problem. A higher total score means this shall be given a greater priority in your adolescent

program. Scores (low, moderate, high) are subjective, so it's important to arrive at a consensus when scoring. An example appears on the next page.

In the example, Healthy Nutrition encompasses both under- and over-nutrition as well as the different micronutrient deficiencies. Obesity has a low prevalence so it rates a 1 (low) in terms of magnitude of the problem. Adolescents and the community see this as of moderate importance, so it rates a 2 (moderate). Another nutrition problem is anaemia. This is very prevalent (rates 3), but the community may not perceive it as a major problem (rates 1). Using the same criteria, within another outcome, early pregnancy merits scores of 3 and 3. Comparing the total scores, early pregnancy is the highest priority (score of 6).

Formula objective

After selecting priority health problems, formulate your health status objectives. Health status objectives are long-term outcomes. These objectives shall be SMART:

S pecific
M easurable
A ttainable
R ealistic
T ime-bound

Annex D offers a menu of indicators and its definitions. To turn these into SMART objectives, refer to available baseline data, and target year for achieving this objective. Write this under Indicators and Targets in your program matrix. Write the Source of Data that will provide you with the measurement of your indicators. Write what Important Assumptions affect the achievement of your objectives. In the example, a SMART health status objective would be to decrease age-specific fertility rate from 57 to 54 live births per 1,000 adolescent women in 5 years. Your local civil registry can provide you with the number of children born to adolescent mothers and the total population of adolescent women.

Analysis of contributing behaviours and other factors

Now that you have the what of your Health Status Outcomes, it is time to analyse the why. There are many methods for doing this. One method is the problem tree. Draw the trunk of the tree and write down your health problem, e.g. increase in cases of early pregnancy. Then go to the roots and write down the primary cause(s) of this problem, e.g. unprotected sex and, in some areas of the country, child marriage. Then ask why there is this primary cause, e.g. lack of access to contraceptives, use of alcohol and/or drugs, sexual abuse, peer norms. These are your secondary causes. Then ask why there are these secondary causes, e.g. lack of access to services and information, poor parental monitoring and communication. These are your tertiary causes. Keep asking why until you get to the fifth level.

Now, go to the branches of the tree. What is the most immediate effect of early pregnancy? This could be health complications arising from pregnancy and delivery, (premature delivery, small babies), dropping out of school. The secondary effects could be maternal death, newborn illness or death, increased family expenses.

The problem tree may look like below.

FIGURE 17. Sample Problem Tree

EFFECTS

- Increased family expenses
- Health complications
- Dropping out of school
- Maternal deaths
- Decreased prospects for livelihood
- Newborn deaths

Increasing cases of early pregnancy

CAUSES

- Unprotected sex
  - Sexual
  - Peer
  - Abuse
  - Norms
- Child marriage
  - Cultural norms
- Lack of access to contraceptives
- Lack of access to services and info
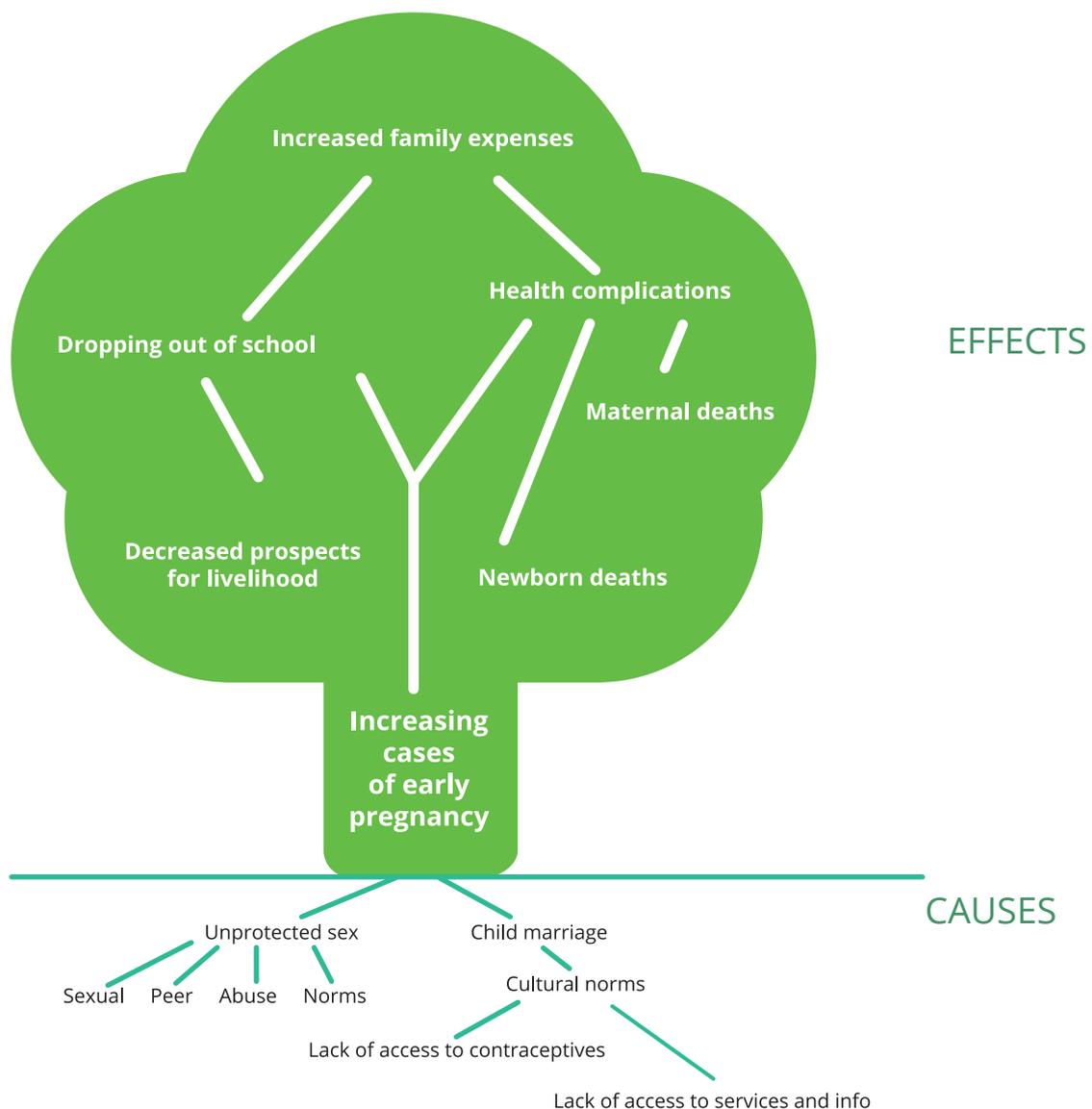
Another tool for analysing the problem is the Fishbone Analysis. You'll find this method is particularly useful when you're trying to solve complicated problems.

There are four steps to using this method:

• Identify the problem.
• Work out the major factors involved.
• Identify possible causes. Draw a fishbone diagram
• Analyze your diagram.

A useful way to use this technique with a team is to write all of the possible causes of the problem down on sticky notes. You can then group similar ones together on the diagram.

Which root causes can you easily address? E.g. there are ways to increase access to services and information, parental monitoring and communication. Causes such as cultural norms, poverty, and corruption cannot be addressed by a health program alone. These call for multi-sectoral action. Take the causes to be addressed and write them under Contributing behaviour & other factors in your Program Matrix.

The strategies you choose in Step 4 will depend on these identified behaviour and factors.

FIGURE 18. Sample Fish Bone Analysis
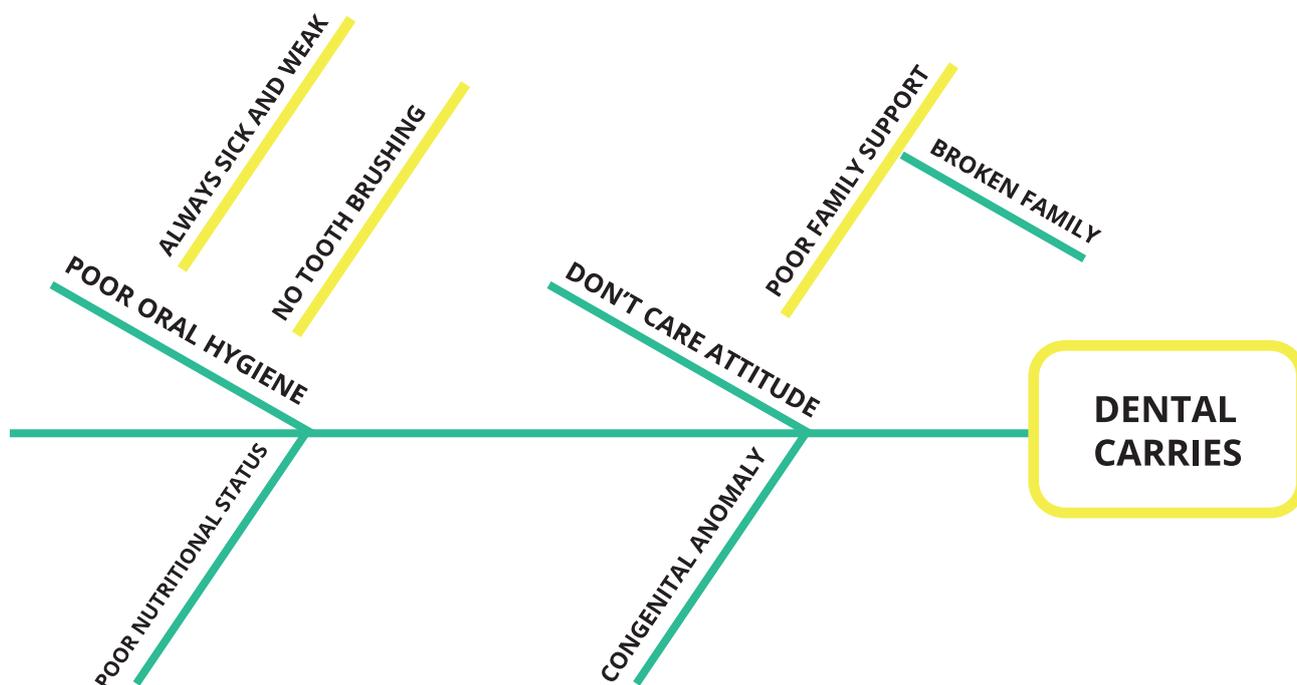
Step 4: Identify program strategies

The main objective of this step is to select strategies that will help you achieve the health status and behavioural objectives you defined in Step 3 (Health Status and Behaviour).

In this step, ask:

- What strategies will address the root causes identified in the previous step? This is your main question in this step. See Section 4 for suggested strategies.
- What internal strengths (including resources) and weaknesses (gaps) do we have as a TWG? (You have answered this is Step 1.) See Sample Worksheet 2.
- What external opportunities and threats do we have to be aware of? See Sample Worksheet 2.
- In choosing a strategy, how do we maximize our strengths and opportunities?
- In choosing a strategy, how do we minimize the effects of our weaknesses and threats?

Develop medium term strategies that would mitigate the risk and provide the protective factors that are the determinants of your target outcomes. The AHDP utilizes strategies to achieve its objectives. These are enumerated in Section 4.

Applying all these strategies could be unrealistic given your time, manpower, and financial resources. You will need to prioritize strategies as you did for your health outcomes. You might begin by using a SWOT analysis.

SWOT stands for Strengths, Weaknesses, Opportunities and Threats. Strengths and weaknesses are internal to the team or organization, while opportunities and threats are external. You might think of yourself as a movie superhero, with your strengths being your superpowers such as flight or x-ray vision. Weaknesses can be things such as kryptonite or needing to protect your friends, which your enemies can take advantage of. Opportunities are your fellow superheroes that can help you and threats would be the villains you encounter.

SWOT analysis focuses attention on the match – or lack of match – between what your team is ready to offer and what the adolescents need and want. Discuss your strengths, weaknesses, opportunities and threats and plot them on the SWOT matrix. You

can find the blank matrix in Worksheet 2 in the Annex. The sample is in the next page. You can use the following questions to guide your discussion.

Strengths

- What advantages or assets does your team have?
- What unique or lowest-cost resources are available within your team?
- What are your staff's capabilities? What is their expertise?
- What do you have that will make your program sustainable?

Weaknesses

- What areas do you need to improve on?
- What necessary expertise/manpower do you currently lack?
- Do you have adequate financial resources?
- Do you have adequate staff?
- What are adolescents and the community likely to see as your weaknesses?

Opportunities

- What external changes present interesting opportunities?
- What trends might impact your program?
- Are there experts outside your team that might be able and willing to help you?
- Is there an unmet need/want that you can fulfill?

Useful opportunities can come from such things as:

- Changes in technology
- Changes in government policy related to your field
- Changes in social patterns, population profiles, lifestyle changes, and so on
- Local events

Threats

- Are the key staffs satisfied in their work? Could they be attracted to leave?
- What if there is a natural disaster?
- What obstacles do you face?
- Are there new government regulations that affect your program?

Further SWOT tips below:

- Apply it at the program level. Think about the programs all the organizations and agencies represented by your team.
- Ask the tough questions during a SWOT Analysis to best understand the nature of the environment your program faces. Then, take action on your findings. Also, if you're having any difficulty identifying strengths, try writing down a list of your team's characteristics. Some of these will hopefully be strengths!
- Match your strengths with your opportunities. A useful approach when looking at opportunities is to look at your strengths and ask yourself whether these open up any opportunities. Alternatively, look at your weaknesses and ask yourself whether you could open up opportunities by eliminating them.
- Only accept precise, verifiable statements ("Four nurses and midwives trained on counseling", rather than "Strong capacity.").
- Ruthlessly prune long lists of factors, and prioritize them, so that you spend your time thinking about the most significant factors.
- Make sure that options generated are carried through to later stages in the strategy formation process.

How to select the appropriate strategies for our program?

Go back to your problem tree or fishbone analysis. Using the filled out fishbone diagram, one can identify respective solutions or interventions to the identified problems. You can use stick notes or metacards and place them beside the causes of the problem to identify which strategy or strategies can address which causes. In the fishbone diagram below, the coloured boxes represent interventions that link to the roots of the problem. For example, providing oral hygiene supplies address the lack of money to buy supplies.

After the intervention diagram has been drawn out, gather all identified interventions and prioritize which ones are to be implemented, especially if numerous interventions are identified. This will help program managers choose the ones that will produce results, at the shortest period of time. You can use a matrix

similar to the one you used to prioritize problems. Prioritization of interventions may be based on:

- Expertise: Do you and/or the health providers have the necessary skills and training to deliver the intervention?
- Return of investment: Given the amount of resources and effort needed to implement the intervention, do you anticipate a significant improvement in your health status indicators?
- Effectiveness of intervention: Is there evidence that the intervention worked globally or in other parts of the country?
- Ease of implementation: How easy is it to implement the intervention in your locality? Is it simple or complicated? What barriers do you anticipate? What resources are present that will enable implementation?
- Potential negative consequences: Are there side effects to the intervention? Will it do more harm than good?
- Legal considerations: Are there legal impediments to the application of the intervention?
- Impact on health systems: Will it strengthen the health system?

You can also use your SWOT to identify which of the seven major strategies is the best fit, i.e. takes advantage of the combination of your strengths and opportunities. These are your strategic options. For every health status objective, choose the appropriate, effective and doable strategies.

For example, based on the SWOT above, one can consider the option of providing adolescent-friendly health services in satellite sites like the schools. A public-private partnership between the government health facilities and private practitioners and establishing a service delivery network are also strong potentials. Expanding peer education is possible because there are existing trained peer educators who can recruit new peer educators from schools. Policy change may not be a priority now given the strong anti-RH sentiment in the policy-making body. Once you've selected your health strategies for each outcome, write them in your Program Matrix (Worksheet 3) under Strategy (Output). Also write your Indicators and Targets for each output.

Step 5: Develop an activity plan

The main objective of this step is to plan activities under the strategies you identified in Step 4 (Identify Program Strategies), thus completing Worksheet 3 (Program Matrix).

In this step, ask:

- How will we deliver on the strategies? What activities does this entail?
- Who will be the main person responsible for each activity?
- When will we implement each activity?
- How much will it cost (in terms of money, manpower, and machines)?

Now that you have clear objectives and strategies, it's time to get into the details. An activity plan may be a short-term proposal for what you want to do. This is also the time to parcel out tasks and responsibilities among team members.

Program activities fall into one of components of the AHDP:

- Nutrition
- Oral Health
- Vaccine Preventable Diseases
- Injuries
- Violence
- Mental Health
- Sexual and Reproductive Health
    - Family Planning
    - Safe Motherhood
    - HIV and STI
- Substance Abuse
    - Drugs
    - Alcohol
    - Tobacco Use

Refer to the Program Components in Section 2 to know more about these components and how they apply to your local AHDP.

Completing the Program Matrix

Once you've selected your Major Activities, place them in your Program Matrix under the relevant Output. Indicators and targets for activities (Process Indicators) may be listed in the short-term activity plan (Worksheet 5).

Identify the sources of funding for your activities. The expectation is that the LGU budget is the main source of funding. You may also have to list some activities as unfunded if you are still unsure of where to get the budget for it or if you will have to do fundraising to cover these costs.

Step 6: Implement and monitor

The main objectives of this step is to conduct the activities, following the plans you made from Steps 1-5 and continuously gather data to gauge if your plans are working.

In this step, ask:

• How will I know if the program implementation is going well?
• What will I do if it is not going well?
• What data do I monitor? Refer to your Worksheet 3 (Program Matrix) for the indicators and the sources of data.
• How will I use the data to make changes in strategy, targets or other programming decisions? If you aren't meeting your short-term targets, you might consider changing your approach, for example, pouring more effort into reaching out-of-school rather than in-school adolescents.
• What is the role of the TWG now that implementation has begun? Your TWG might change from a strategy/ program planning group to a monitoring and internal audit group. If so, you need to review the TWG membership and ways of working.
• How often shall the team meet to monitor progress? When you are just starting the program, it may be good to have monthly meetings. Later on, when the program is running smoothly, you can meet, say, quarterly.

Before you implement, give your program strategy a final review by going back to your indicators in Worksheet 3 Program Matrix. Copy your indicators into Worksheet 4 Results Chain. Looking at your program on a Results Chain ensures that your activities (process) match your strategies (outputs), and that your chosen strategies will result in your health status and behavioural (outcome) objectives.

Also, think about how you're going to monitor and evaluate your program. Consider setting up a system to monitor client, i.e. adolescents or client satisfaction survey, such as a dropbox for comments and suggestions, exit survey, or focus group discussions. Also when conducting health education, providing pre and post test among the participants can help you to assess or evaluate the knowledge that they will learn. Using client feedback, you can quickly gauge how your program is doing from the point of view of your target group, i.e. adolescents.

Now, it is time to implement. As you put your plans in motion, it is important to continuously monitor your program so you can detect new developments and address them quickly. Before you implement, gather baseline data. Baseline data are your indicators at the start of your program. These are the numbers you start with. These shall improve after you implement your program. After getting a baseline, set you targets for the short- and medium-term.

Though there is no formula for this, it is important to have a basis for setting targets. For example, a decrease in age specific fertility rates by a mere 3 births per 1,000 women, given that there are 9 million women 15-19 years old in the Philippines, would mean that the program would have to prevent about 27,000 pregnancies. Therefore, the degree of decrease in sexual activity along with the degree of increase in contraceptive use shall be able to achieve this outcome. Targets could also be based on program experience. Look back at your program records. Were you able to decrease birth rates with your current strategies? Will you need to raise your target reach (outputs) for contraceptives to be able to meet your outcome objectives? Or will you need a totally different strategy altogether? Perhaps, too, you have overshot your targets the previous year, so this calls for you to be more ambitious in setting new ones. Arrive at a consensus on your targets. Include your DOH-Regional Office so you will know if your targets are high enough for the Regional and National Offices to meet their own targets.

Take your Worksheet 3 (Program Matrix) and transfer the contents into the corresponding boxes in Worksheet 4 (Results Chain). Do this to check if all your activities correspond to at least one of the outputs/ strategies. In turn, will the strategies bring a change in behaviour and improved health outcome? If the target outcome is achieved, will this contribute to your goal of improved health status and enjoyment of rights?

Step 7: Assess and evaluate

The main objective of this step is to determine if your program has worked and brought about change in health status and behaviour.

In this step, ask:

- How to measure changes in health status and behavior? Menu of indicators are listed in Annex D.
- What are the sources of data?
- How will the data be analyzed?

You already wrote your indicators and sources of data in your Program Matrix. You might have several indicators that can only be measured by a survey. If you can't conduct a survey, you need to be innovative in order to acquire the data you need. Perhaps you can gather qualitative data through focus group discussions or interviews. Keep in mind, however, that this will be qualitative and will not give you the quantitative data you need to report on. Utilize the Program Monitoring Forms, see them at Annex part.

Now consider how you will use the data to plan your next program cycle. A common practice is conducting an annual program review followed by an annual planning workshop or strategic planning. However, you shall not wait for the end of the year to monitor program implementation. You shall have a way of identifying and responding to problems as soon as they appear. Regular, e.g. quarterly, reports to the team can help you. You may also want to consider meeting regularly to see if there are any problems that need an adjustment in the program strategies and how far you are progressing towards your targets. You can also come up with your own checklists and forms for monitoring your program.

Every 3-5 years of program implementation, a program evaluation would be valuable. Unlike an annual review, a program evaluation looks at outcome indicators, e.g. decrease in adolescent fertility rates or decrease in proportion of current smokers.

Strategies for Improving the Adolescent Health and Development Program

4.1   Managing the Adolescent Health and Development Program

The values, mission and overall commitment of an agency, organization, institution, health centre or clinic can have a huge authority on the professional culture of health care providers. The most effective way for health services to respond to adolescent health is for the whole agency to make an action to the issue instead merely distributing the task fall on the shoulders of individual providers. Ideally, program managers and coordinators should be aware of adolescent health and development program as a public health problem and human rights, and they should be the champions for efforts to improve the health service response.

A list of key strategies of quality health care for adolescents: Below are strategies on key areas of quality care and a brief discussion of why these strategies are important in response to adolescent health and development program. It is also important to note that before identifying the list of the strategies, program managers should also know how to assess the current status of the implementation of their programs, and here is a sample AHDP Management Checklist.

AHDP Management Checklist: This is a checklist that contains specific questions to assess what measures an agency, institution, or organization has taken to ensure an adequate response for adolescent health program implementation. Managers, programmers, or health care providers can use this checklist for program planning or monitoring and evaluation.

TABLE 4. AHDP Management Checklist (adapted and revised from IPPF/WHR Tools)

No.	INSTITUTIONAL COMMITMENT	Yes	No
1	Are the senior management or heads of the institutions sensitized about adolescent health and development as a public health problem?		
2	Have they voiced their support for the effort to address the adolescent health program as a public health problem?		
3	Has the agency made an explicit commitment to adolescent friendly health care services, ideally in writing?		
4	Have you identified individuals in your institution or health centre that will lead or handle the adolescent health and development program?		
5	Do you have funds allotted for the implementation of the AHDP?		

	REFERRAL NETWORKS AND PARTNERSHIPS		
6	Have you met with representatives from other institutions, organizations, or health centres working in the area of adolescent health and development program to identify how you can work in partnership?		
7	Is your agency or health centres part of a network or technical working group of organizations that works on issues related to adolescent health and development?		
8	Is your institution or health centres does have a directory of referral services in the community that can help adolescents in accessing services or any interventions?		
8	Do these directories include specific information about what kinds of services are available, how to access them (e.g. phone numbers, procedures, costs, etc.), and a contact name?		
9	Do these directories include resources for special groups such as indigenous populations, adolescents with disabilities, adolescent key population, adolescent living with HIV etc?		
10	Is the directory accessible to all health care providers in your health centre (for example, by distributing a copy to each staff member or by ensuring that at least one directory is located in an accessible place in each health centre)?		
11	Has the health centre gathered feedback from providers about the directories?		
12	Has the health centre developed a way (either formal or informal) to monitor the quality of referral services in the community?		
	LOCAL SUPPORT OR TECHNICAL ASSISTANCE		
13	Have you identified individuals and/or organizations in your area that could support efforts to sensitize and train health care providers on issues related to adolescent health and development?		
14	Have you identified individuals and/or organizations in your area that could assist your institution with the legal issues related to adolescent health and development?		

	PRIVACY AND CONFIDENTIALITY		
15	Are consultation rooms built in such a way that clients cannot be heard or seen from outside?		
16	If consultation areas can be overheard from outside (for example, if curtains are used to separate consultation areas), has the institution worked with providers to develop strategies to ensure privacy despite the limitations of the infrastructure?		
17	Does the institution or health centre have written policies about confidentiality that explain the following: • How to ensure that health centre records are kept in a secure place?		
18	Does the institution or health centre have written policies about confidentiality that explain the following: • Which staff members have access to medical records?		
19	Does the institution or health centre have written policies about confidentiality that explain the following: • Where and when staff are allowed to discuss confidential information with or about clients (e.g. not in the waiting room, not in front of other patients, etc.)?		
20	Does the institution or health centre have written policies about confidentiality that explain the following: • Whether adolescents have the right to keep their medical and personal information confidential from their parents or whether parents have the right to access their adolescent children's medical records without their consent?		
21	Does the institution or health centre have written policies about confidentiality that explain the following: • Whether and when health care providers should report cases of physical or sexual violence to the authorities?		
22	If any reporting requirements do exist, what process should providers follow for obtaining a client's consent? When the client is minor.		

	HEALTH PROMOTION AND COMMUNICATION		
23	Have all staff in the institution or health centre participated in sensitization workshops that explore adolescent health and development as a public health problem?		
24	Have all staff who have direct contact with clients received in-depth trainings about: • Adolescent Job Aid? • ADEPT? • HEEADSSS? • Gender-based violence? • HIV and AIDS? • Adolescent Friendly Health Services?		
25	Is there a mechanism to sensitize and train new staff members soon after they are hired?		
26	Is there a mechanism to provide ongoing and repeated training concerning both general and specific issues related to adolescent health and development?		
27	Is there a mechanism for distributing written, educational information on adolescent health (bulletins, memos, etc.) among the health staff on a regular basis?		
28	Have health care providers received training about legal issues related to adolescent health, including reporting requirements (if any)?		
29	Is there a mechanism to provide emotional support to staff on a regular basis?		

	HEALTH PROMOTION AND COMMUNICATION		
30	Does your institution have the following materials related to adolescent health and development available in all clinics or health centres: • Posters or signs displayed on the walls? Ex. Isip – Isip Before Youth UnZip Health Young Ones FlipTarpaulin		
31	Educational materials to give to clients?		
32	Other types of materials?		
33	Are these materials available in all clinics/health centres?		
34	Have these materials been validated with adolescents?		
	PROTOCOLS FOR CARING FOR ADOLESCENTS WITH SPECIAL NEEDS		
35	Do all clinics or health centres have written protocols for caring for adolescents who experience the following: • Physical violence by an intimate partner or another family member? Adolescents living with HIV?		
36	Internal and external referral services?		
37	Reporting requirements (if any)?		

	SCREENING OF ADOLESCENTS USING HEEADSSS ASSESSMENT		
38	Do all health centres have a written protocol explaining the tools in conducting screening for adolescents, when and how?		
39	Do these protocols address the following: Privacy and confidentiality?		
40	Do you have schedules on when to screen new clients?		
41	Do you have schedules on when to screen returning clients?		
42	Internal and external referral services?		
43	Have all health care providers been trained to follow the assessment tool?		
	DOCUMENTING INFORMATION RELATED TO SCREENING		
44	Is there a system for documenting whether a client has been asked screening questions?		
45	Is there a system for documenting the answers to screening questions (for example, a designated form printed or stamped onto the clinical history form, or a separate registry)?		
46	Is there a mechanism for gathering and analyzing data on services related to adolescent health and development (for example, how many adolescents receive counselling services in a given year, monitoring tools or forms)?		

	FOLLOW-THROUGH ON REFERRALS AND COUNTER-REFERRALS		
47	Do you have referral forms?		
48	Is there a mechanism to verify if a client went to referral services outside the health centre?		
49	Do you follow up to your clients even right after you referred them already?		
50	Has the institution or health centre made an effort to verify the quality of services provided at external referral services?		
	MONITORING AND EVALUATION		
51	Has the institution gathered baseline information on health care providers' knowledge, attitudes, and practices?		
52	Has the health centre staff faithfully document all the services provided in the monitoring forms?		
53	Has the institution gathered clients' perspectives on the health service response to adolescent friendliness of the facility?		
54	Has the institution monitored the quality of care on an ongoing basis? Do you gather client's satisfaction survey within the health centre?		
55	Has the institution measured changes in health care providers' knowledge, attitudes, and practices over time?		

List of Key Strategies

4.2 Ensuring Privacy

One important step that a health program can take to improve the quality of care for adolescents is to strengthen the organization's commitment to privacy and confidentiality within health services. Privacy and confidentiality give adolescents the confidence to reveal a history to their health care provider. For example, they also protect adolescents from future violence, as adolescents who tell health care providers that they are experiencing abuse may be at risk of further violence if the aggressor finds out that the adolescents has revealed this information. Furthermore, revealing other health related information—such as that a adolescent is pregnant, has had an abortion, or has a sexually transmitted infection—can place the adolescent at risk of violence if that information is shared with family, friends or employers without permission.[11]

Potential consequences of lack of privacy and/or confidentiality in a health clinic
(adapted and revised from IPPF/WHR Tools)

Adolescents affected by gender-based violence	What can happen in a clinic that lacks privacy and confidentiality	Potential consequences for adolescents
Adolescents who have experience violence in the past	Adolescents may not feel safe enough to disclose past experiences of violence to health care providers	Adolescents may miss an opportunity to seek help
		Adolescents may receive inappropriate care because providers misinterpret or misdiagnose their health status.
Adolescents currently living in a violent situation	A violent family member may find out that a woman has told a health care provider about the violence	Adolescents may experience more violence in retaliation for having disclosed the situation to a health care provider.
Adolescents whose partner or family members have the potential to react with violence	A health worker may reveal confidential information to a partner or family member without the woman's conSent. (For example information about her pregnancy status, use of contraceptives, STI diagnosis, abortion	A partner of family member may react with violence after learning the confidential information revealed at the health center.

Sample Recommendations on Ensuring Privacy
(adapted and revised from IPPF/WHR Tools)

Key concerns regarding Privacy	Challenges	Recommendations
Do the clinics have enough private space? • Is there enough space for health care providers to consult with adolescents individually? • Is there enough space to collect information in a private room rather than the reception area?	Many health centres do not have enough private consultation rooms to meet with adolescents individually. Some health centres have private rooms for doctors, but not for counselling adolescents or for collecting information.	To overcome these challenges, health care providers can increase the amount of private space available by using space more efficiently (e.g. cleaning out a back room), dividing rooms in two, or actually expanding the health centre. If this is not possible, they should consider ways to adjust patient flow, for example, by reassigning responsibility for collecting intake information from a receptionist to a different provider.
Can patients be seen or heard from outside consultation rooms? • Are the walls and doors of consultation rooms solid enough to prevent adolescents from being seen or overheard from outside the consultation room, such as hallways, adjoining rooms or reception areas? • Are curtains used to separate any consultation areas?	In resource-poor settings, many consultation areas can be seen or heard from hallways or adjoining areas because doors or walls are thin or nonexistent. In some cases, health centres use curtains to separate consultation areas. Ideally, heath care providers would be able to strengthen the walls and doors of consultation rooms to ensure privacy.	**When this is not possible, however, health care providers, can take a number of steps:** a) they can work with staff to determine whether it is possible to speak more softly so that they cannot be overheard; b) they can ask colleagues to vacate adjoining rooms or hallways in selected cases; and c) they can develop policies to ensure that discussions about sensitive information are restricted to those areas of the health centre that are in fact private. (DOH Policy on ensuring privacy is written at the Standards on Adolescent Friendly Health Services (AFHS).
Do staff members protect adolescents' right to privacy in practice? • Do receptionists or any personnel at the receiving area ask adolescents to state the reason for their visit in front of other patients in the reception area? • Do staff members collect intake information in the waiting room? • Do staff members routinely interrupt or walk in on consultations or counselling sessions?	In many health care settings, health workers routinely fail to ensure adolescents' privacy. For example, it is common for receptionists to ask adolescents to state the reason for their visit in front of other patients in the reception area—even though adolescents may consider that information to be highly personal.	Similarly, in some centres, health workers collect intake information (such as name, address, medical history) in public areas such as the waiting room, or they walk in on consultations without knocking. When these problems exist, health care providers should work with staff to reduce these practices. For example, staff should severely limit what they ask adolescents to say in reception areas; they can try collecting information in writing if adolescents know how to read and write. Otherwise, staff should wait until they can meet with them in private before asking them to share personal information out loud. (Sample strategies on how to ensure privacy can be seen at the ADEPT e-learning).
Have staffs been trained to understand the importance of clients' privacy? • Have all staff, including receptionists, been trained to understand the extent to which a breach of privacy and confidentiality can put adolescents' health and safety at risk?	In many settings, health centres or even hospitals, respect for privacy and confidentiality has simply not been a part of the professional culture within health services, either because of space limitations or because it has not been a priority of the org anization.	Managers can address this by ensuring that all staff members are trained to understand the potential risks of lack of privacy and confidentiality. (DOH Adolescent Job Aid Training and ADEPT e-learning offers discussion on the importance of privacy and confidentiality).

Do adolescents have the opportunity to see health workers without parents, family, partners, or friends?	Many adolescents want their parents, family members or friends to be present when they meet with a health worker, and health centres need to respect their wishes. However, health care providers also need to understand that in some cases, the parents or family member accompanying the adolescents may be an abuser, may have the potential for violence, or may reveal confidential information to a violent member of the household.	Health care providers need to work with staff to develop policies about when to allow family and friends to accompany adolescents at different stages of the consultation. These policies should balance the need to protect adolescents' privacy with the need to respect adolescents' preference for having a family member or friend present during the consultation. Protecting adolescents' privacy may require that providers understand the potential risks, use their judgment about what information to discuss in front of family members, and find creative strategies to obtain consent and to distract family members who may actively try to prevent adolescents from consulting a health worker in private. Provide leaflets or reading materials to the accompanying adults and explain to them that health care providers should meet the adolescents privately.
• Do providers know creative strategies for getting a moment alone with adolescents to ask whether she/he would like to discuss anything without her/his parents, family members or friend present? • Are providers aware that the person who accompanies the adolescents may be or may reveal • information to other people or to perpetrator of violence for example? • Do providers ask adolescents about sex, sexuality, or violence in the presence of partners, parents, family members or friends? • Do health workers know how to distract a family member or friend long enough to ask an adolescents about abuse when they suspect that the adolescents has been a victim of violence or any related sexual and reproductive health concerns?		

4.3 Strengthening Confidentiality

Confidentiality is an essential component of quality care and patient rights in any health-care setting. It increases the willingness of an adolescent to seek care and utilize health services available. Most teenagers appreciate it when they can talk with someone outside of the presence of any parent. The teenager prefers to have some time alone with the provider to discuss certain issues. Even if the complaint may be as simple as cough and colds, there may be some underlying concern that the teenager is not ready to divulge in the presence of his parents. [11]

Many problems of adolescents are rooted in behaviours that may not be revealed unless the health provider opens his lines of communication with the teenager. However, confidentiality is particularly important when adolescents experience early pregnancy, violence or within any HIV related concerns, because breaches of confidentiality can have life-threatening consequences for adolescents living or facing in situations of early pregnancy, violence and HIV.

Sample Recommendations in Strengthening Confidentiality
(adapted and revised from IPPF/WHR Tools)

Key concerns regarding confidentiality	Challenges	Recommendations
Are medical records stored in a secure place? • Are clients' medical records kept in a secure place that can be locked and is closely supervised? • Do the health centres have written policies about who is allowed to access client records? • Has the health centre raised staff awareness about the importance of guarding the confidentiality of medical records?	In any setting, breaches of confidentiality can occur if medical records are kept out in the open, in an unsecured place, or in reach of anyone who comes into the clinic. Moreover, in many health centres, patients may see whichever doctor is available that day, rather than having their own personal physician.	In such settings, many different health workers have access to medical records. Each health centre should develop policies about who can access medical records and under what conditions. Managers or coordinators should train staff to understand the risks of breaching confidentiality.

Does the health centre have clear policies about confidentiality, including: • Whether and when they are allowed to share information with: • Other staff members? • Parents of minors / Family members? • Local law enforcement authorities? • When and how staff should obtain consent from adolescents before • sharing information about her situation to a third party? • Informing adolescents about any limits to confidentiality?	Health workers often face difficult questions about whether and when to reveal medical information about a patient. For example, if an adolescent girl has been beaten or raped by her boyfriend, or if she is pregnant, do the parents have a right to know? What if the girl wants to keep this information secret from her parents? What if there is evidence that the girl's family will subject her to further abuse or mistreatment? Is there a legal requirement to report this information to the authorities? What if the local law enforcement system itself is abusive? Does the clinic want to follow the legal reporting requirements? These are questions that should be addressed at the level of the health centres through norms and policies.	Health workers should participate in developing those policies, but they should not be forced to make these decisions alone without guidance or support from the institution. The issue of confidentiality has been identified as a significant barrier to access to health care by both the health provider and the adolescent. Most parents, once they have been made aware of the rules of conduct in the clinic, will allow the teenager some time alone with his provider. Let the parent know why this is being done and that your plans will be discussed with them after you have made a thorough evaluation of their child. (DOH Policy on ensuring confidentiality is stipulated at the Standards on AFHS. It is also discussed at the ADEPT e-learning toolkit, and Adolescent Job Aid Manual.)
Does the staff have basic knowledge and awareness about the importance of confidentiality? • Are the staffs understand why a breach of confidentiality can put an adolescent at great risk? • Are the staffs trained not to reveal client information without permission? • Does the staff know what kinds of information, if any, it is legally required to report to the authorities, for example, evidence of physical or sexual abuse of adolescents, or physical violence against girls, boys, or LGBT • Does the staff know how to handle HIV counselling and testing? • Is there a mechanism in the health centre for getting feedback from staff about how well the health centre policies are working?	Some health centres or hospitals do not have any written policies about confidentiality. In other cases, norms and policies about confidentiality exist, but were not developed with adequate participation or feedback from providers. In many settings, policies exist on paper, but the staff has not been adequately informed about what the policies are and what they are expected to do. If providers disagree with a policy or find it unworkable, they may simply ignore it.	Ideally, every organization or health centre would develop norms and policies about confidentiality, with the participation of staff. The next step is to ensure that health personnel actually know what the policies are, support those policies, and understand the reasons behind them. When the management involves providers in developing the policies and monitors how well those policies work, it can resolve problems and refine the system to ensure that patient confidentiality is better protected.

4.4 Enhancing Capacities of the Health Care Providers

In the effort to change providers' attitudes, beliefs, knowledge, and practices, it may be helpful for managers to think about sensitization and training as two distinct but related stages, as follows:

> **Sec. 5.29 of the RPRH Law IRR states that the DOH shall develop a curriculum to train skilled health professionals in counselling about adolescent reproductive health, determining age- and development-appropriate methods or services, and referring adolescents to the appropriate facilities within the reproductive health care SDN**

Sensitization

Sensitization can be described as the effort to educate and to raise awareness about the magnitude, patterns, dynamics, and consequences of adolescent health issues. Sensitization can educate staff about the needs of adolescents who experience concerns and how the health sector can help meet those needs. Above all, sensitization can help persuade health professionals to view adolescent health and development program as a public health problem and human rights. Ideally, organizations should try to sensitize staff from all levels of the institution, including boards of directors, senior managers, health care providers, barangay health workers, guards, receptionists.

Training

In contrast, training is aimed at improving specific kinds of knowledge and skills, such as how health care providers can identify cases of adolescent concerns that will fall under the AHDP components. For example, violence, discusses violence with adolescents, provide emotional support, and refer adolescents to other services. Health care organizations can arrange training for health professionals, such as physicians and nurses, as well as other kinds of frontline staff, such as barangay health workers, receptionists and security personnel, who often have direct contact with clients. Health care managers and administrators could also receive training as they may play an essential role in designing ways to improve the delivery of clinical services.

Health organizations can approach the need for training in a variety of ways, including:

- holding intensive training workshops for staff with the help of outside experts or institutions;
- sending selected staff to courses or workshops in other organizations or universities;
- hiring new staff with specific expertise in the area of gender-based violence;
- arranging for ongoing training and support from individuals or organizations with specific expertise in areas such as psychology or law;
- distributing written educational information to providers on a regular basis; and
- incorporating the issue of adolescent health and development into other training workshops for health care professionals.

Department of Health List of Capacity Building on AHDP

The Department of Health (DOH) has developed the following capacity building for health care providers:

A. Competency Training on Adolescent Health for Health Service Providers (Reference Material)

Is a resource material for adolescent health personnel and other personnel from government and non-government agencies nationwide involved in the delivery of adolescent health services.

This reference material is composed of six major parts:

Part 1: The Adolescent-Friendly Health Services and the Risk Behaviors of Adolescents
Part 2: General Health Concerns
Part 3: Mental Health and Psychological Concerns
Part 4: Sexual and Reproductive Health Concerns
Part 5: Maintaining a Healthy Lifestyle
Part 6: Adolescents in Emergencies

C. Adolescent Job Aid Training
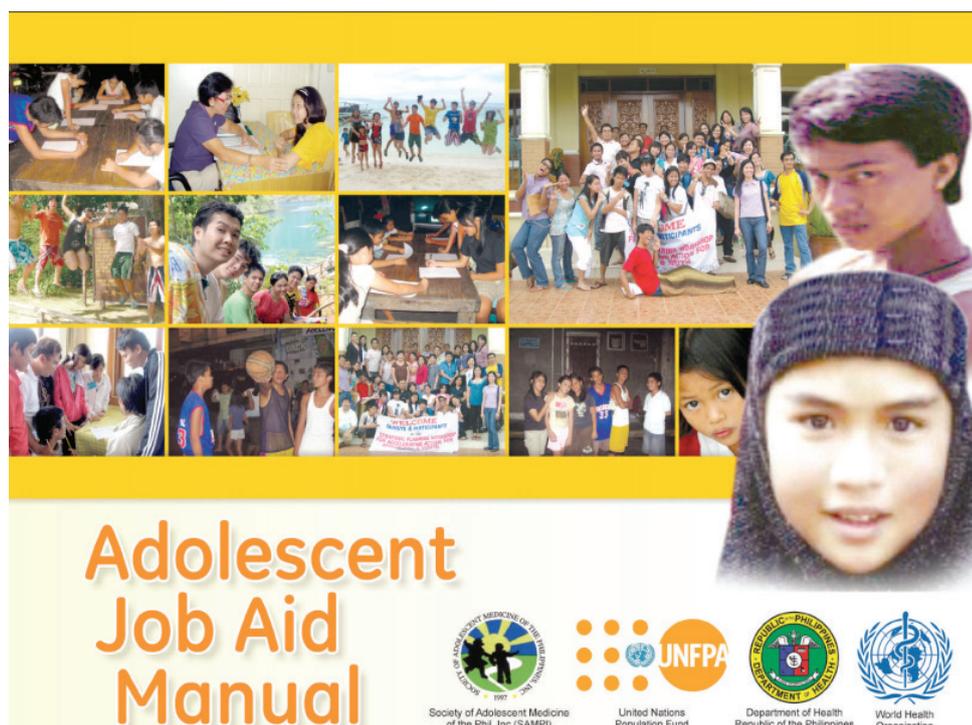
This job aid manual is intended to complement the reference manual A Practical Guide on Adolescent Health Care. It is a step-by step manual that can be easily referred to based on a patient's chief complaints. It deals with some specific health conditions which have not been dealt with in the Practical Guide. It will focus on concerns of teens based on Focused Group Discussions with several field workers and adolescents themselves. Experts in the fields of Adolescent Medicine, Obstetrics and Gynecology, Dental Medicine, Public Health, Teachers, Psychiatrists, and adolescents.

C. Adolescent Health Education and Practical Training (ADEPT) for Heath Care Providers E- Learning Toolkit
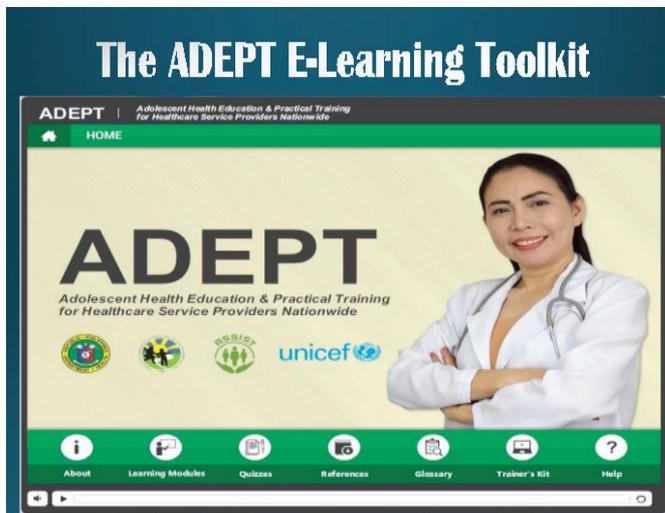
Naturally, many healthcare service providers who work with adolescents on a daily basis tend to feel uncomfortable dealing with that aspect of life. Often health professionals also struggle to overcome personal biases, particularly, when a young patient is diagnosed with a sexually transmitted disease or turns out to be pregnant. Altogether there is big gap in communication between the healthcare service providers and the adolescents.

Clearly, there is a need to educate health professionals about the proper ways of dealing with adolescents: building trust, encouraging openness, asking the right questions in a right manner. To increase access to such quality capacity-building, the training should be cost effective and will not require physical attendance to complete the course.

This e-learning knowledge product is designed for healthcare service providers who work with adolescents in the field of adolescent health.

The toolkit can be used for self- and group-based learning, and can be conducted for 1 – 2 days, most especially if you do not have enough funds to conduct full duration of training. There are practitioners, who just distributed the copy of ADEPT and required to pass their certification, as basis that they finished the e-learning. You may access training on this toolkit from DOH AHDP Regional Coordinators.

It is comprised of the following modules:

MODULE	TITLE
1	Adolescent-Friendly Health Services
2	HEADSSS Interview
3A	Taking Sexual History
3B	Positive Pregnancy Test
4	Adolescent Sexuality
5	Alcohol, Tobacco and Other Drugs (Substance Use and Misuse)

D. The HEEADSSS Interview Tool

In the AJA Manual and ADEPT e-Learning Tool, you will find a concise version of the HEEADSSS interview guide that health service providers can use to carry out a quick psychosocial history and assessment in situations or settings that do not allow for a comprehensive assessment of an adolescent (outreach, etc.). The tool is self-administered. Any "yes" answer warrants further examination.

The HEEADSSS assessment is a screening tool for conducting a comprehensive psychosocial history and health risk assessment with a young person. HEEADSSS also provides an ideal format for a preventive health check. It provides information about the young person's functioning in key areas of their life:

H - Home
E - Education & Employment
E - Eating & Exercise
A - Activities & Peer Relationships
D - Drug Use/Cigarettes/Alcohol
S - Sexuality
S - Suicide and Depression
S - Safety

The following questions provide a guide to conducting a HEEADSSS assessment with a young person.

ASSESSMENT AREA	QUESTIONS
H - Home	**Explore home situation, family life, relationships and stability:** Where do you live? Who lives at home with you? Who is in your family (parents, siblings, extended family)? What is your/your family's cultural background? What language is spoken at home? Does the family have friends from outside its own cultural group/ from the same cultural group? Do you have your own room? Have there been any recent changes in your family/ home recently (moves; departures; etc.)? How do you get along with mum and dad and other members of your family? Are there any fights at home? If so, what do you and/ or your family argue about the most? Who are you closest to in your family? Who could you go to if you needed help with a problem?
E - Education / Employment	**Explore sense of belonging at school/work and relationship with teachers/peers/workmates; changes in performance:** What do you like/not like about school (work)? What are you good at/not good at? How do you get along with teachers/other students/ workmates? How do you usually perform in different subjects? What problems do you experience at school/work? Some young people experience bullying at school, have you ever had to put up with this? What are your goals for future education/ employment? Any recent changes in education/employment?
E - Eating and Excercise	**Explore how they look after themselves; eating and sleeping patterns:** What do you usually eat for breakfast/lunch/dinner? Sometimes when people are stressed they can overeat, or under-eat - Do you find yourself doing either of these? Have there been any recent changes in your weight? In your dietary habits? What do you like/not like about your body? If screening more specifically for eating disorders you may ask about body image, the use of lazatives, diuretics, vomiting, excessive excercise, and rigid dietary restrictions to control weight. What do you do for excercise? How much excercise do you get in an average day/ week?
A - Activities and Peer Partnerships	**Explore their social and interpersonal relationships, risk taking behaviour, as well as their attitudes about themselves:** What sort of things do you do in your free time out of school/work? What do you like to do for fun? Who are your main friends (at school/out of school)? Do you have friends from outside your own cultural group/from the same cultural group? How do you get on with others your own age? How do you think your friends would describe you? What are some of the things you like about yourself? What sort of things do you like to do with your friends? How much television do you watch each night? What's your favourite music? Are you involved in sports/hobbies/clubs, etc.?
D - Drug Use/ Cigarettes/ Alcohol	**Explore the context of substance use (if any) and risk taking behaviours:** Many young people at your age are starting to experiment with cigarettes/drugs/alcohol. Have any of your friends tried these or other drugs like marijuana, injecting drugs, other substances? Have you tried any?- *If YES, explore further* How much do you use and how often? How do you (and your friends) take/use them? - *explore safe/unsafe use; binge drinking; etc.* What effects does drug taking or smoking or alcohol, have on you? Has your use increased recently? What sort of things do you (& your friends) do when you take drugs/drink? How do you pay for the drugs/alcohol? Have you had any problems as a result of your alochol/drug use (with police; school; family; friends)? Do other family members take drugs/drink?
S - Sexuality	**Explore their knowledge, understanding, experience, sexual orientation and sexual practices - Look for risk taking behaviour/abuse:** Many young people at your age become interested in romance and sometimes sexual relationships. Have you been in any romantic relationships or been dating anyone? Have you ever had a sexual relationship with a boy or a girl (or both)? - *If YES, explore further* (If sexually active) What do you use to protect yourself (condoms, contraception)? What do you know about contraception and protection against STIs? How do you feel about relationships in general or about your own sexuality? (For older adolescent) Do you identify yourself as being heterosexual or gay, lesbian, bisexual, transgender or questioning? Have you ever felt pressured or uncomfortable about having sex?
S - Suicide/ Self Harm/ Depression/ Mood	**Explore risk of mental health problems, strategies for coping and available support:** Sometimes when people feel really down they fee like hurting , or even killing themselves. Have you ever felt that way? Have you ever deliberately harmed or injured yourself (cutting, burning or putting yourself in unsafe situations - e.g. unsafe sex)? What prevented you from going ahead with it? How did you try to harm/kill yourself? What happened to you after this? What do you do if you are feeling sad, angry or hurt? Do you feel sad or down more than usual? How long have you felt that way? Have you lost interest in things you usually like? How do you feel in yourself at the moment on a scale of 1 to 10? Who can you talk to when you're feeling down? How often do you feel this way? How well do you usually sleep? It's normal to feel anxious in certain situations - do you ever feel very anxious, nervous or stressed (e.g. in social situations)? Have you ever felt really anxious all of a sudden - for particular reason? Do you worry about your body or your weight? Do you do things to try and manage your weight (e.g. dieting)? Sometimes. especially when feeling really stressed, people can hear or see things that others don't seem to hear or see. Has this ever happened to you? Have you ever found yourself feeling really high energy or racey, or feeling like you can take on the whole world?
S - Safety S - Spirituality	Sun screen protection; immunisation; bullying; abuse; traumatic experiences; risky behaviours. Beliefs; religion; What helps them relax, escape? What gives them a sense of meaning?

E. Healthy Young Ones: User Guide for Primary Healthcare Providers
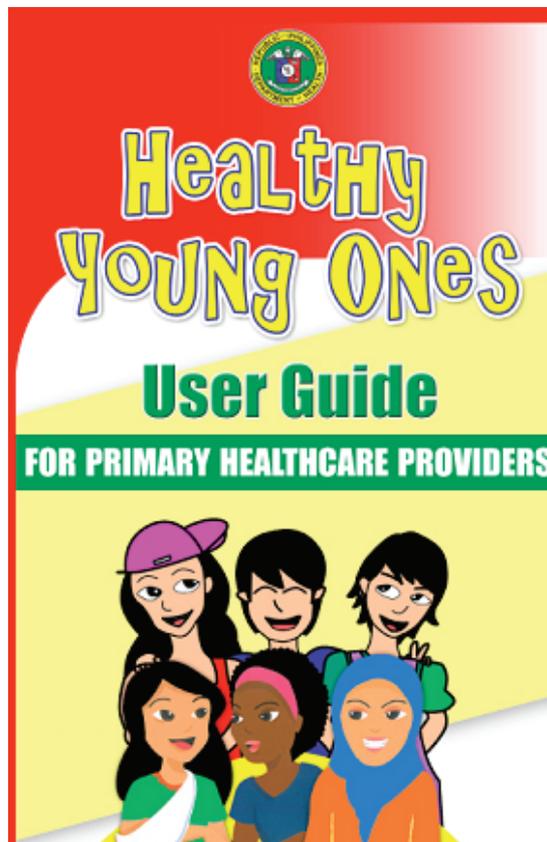
This is a toolkit that healthcare providers can use to inform and educate adolescents on sexual and reproductive health. It offers an opportunity for healthcare providers and adolescents to communicate with each other on matters pertaining to sexual and reproductive health.

The toolkit teaches about sexual health, sexual orientation and gender identity, puberty, reproductive system, sexually transmitted infections, HIV, AIDS and looking after one's safety and well-being. It aims to address the challenge that healthcare providers are facing in providing adolescents information, skills about their self, sexuality, and sexual health.

It includes seven topics that can be cascaded to adolescents through a Flip-Tarpaulin. It can either be delivered in staggered basis over an extended period or in one session. It can be given to single sex group or mixed sex groups.

However, capacity building does not end with a training but with the trained health service providers (HSPs) working in adolescent-friendly facilities. Thus the local government should invest in establishing adolescent friendly facilities or clinics and in quality improvement of health centres, school clinics, counselling centres, and outreach services for adolescents. Post-training support should also be provided, with follow-up field supervision and coaching within one month after the training and continuous monitoring.

4.5 Health Promotion and Communications (Behaviour Change)

The health sector has an important role to play in educating clients and the broader community about adolescent health as a public health problem. One way that health programs can contribute to this effort is to produce or at least distribute information within clinics and community based fora. These materials can include videos for clients and providers, pamphlets that discuss issues related to adolescent health and development in depth, cards with information about local resources, and/or posters that can be put up around clinics or other places in the community.

Health programs may want to create or distribute materials on many different topics that are directly and indirectly related to violence, including:
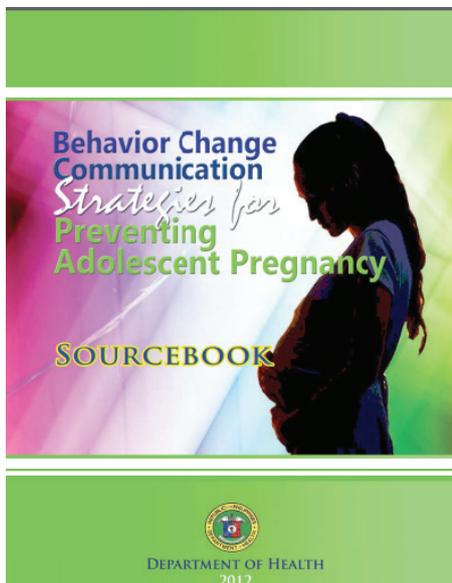
- Patient rights within health services (e.g. for privacy and confidentiality)
- Nutritional Facts
- Safe Motherhood
- Injury Prevention
- Mental Health
- Family and Intimate partner violence
- Sexual violence, including rape
- Childhood sexual abuse
- Adolescent Sexual and reproductive rights
- STI and HIV and AIDS
- Services available for adolescents
- Laws about adolescent health
- Prices of services (if any)
- Location of services

This is the main purpose for which the Department of Health invested in the project: "Development of Behavior Change Communication (BCC) Strategy for Adolescent Pregnancy." This initiative essentially aims to contribute to the promotion of positive and healthy behaviours that enable adolescents to avoid too early and unintended pregnancy. This initiative also aims to set a framework for harmonizing and converging existing as well as recommended communication strategies for preventing too early and unintended pregnancy among adolescents.

While there are limits to the strategies that can be employed, try to approach this step with a holistic view of the adolescent. There should be balance between demand generation and strengthening supply and policy support. For instance, a program could go heavy on information giving or counselling and this could result in too much demand generation, but cannot be met with the supply factors (such as number of adolescent-friendly providers and supply of FP commodities) or not supported by policy or local health system because they were not adequately considered in strategy formulation.

4.6 Roles and Responsibilities of Other Institutions or Agencies on Health Promotion

> **Sec 11.04 the RPRH IRR states that"... measures shall be focused on the development of the following outcomes for children, to include, among others:**
> **-Raising awareness on rights of the child survival, development, participation and protection;**
> **-Providing them with scientificalli-accurate and evidence-based information on the reproductive system,**
> **-Teaching them how to take proper care of their bodies and live a healthy lifestyle;**
> **-Developing health-affirming and health-promoting behaviors;**
> **-Developing informed choices in reproductive health; and**
> **-Developing their capacity to make intelligent options on how to live their life as they enter adulthood.**

Department of Education

A. Comprehensive Sexuality Education (CSE) is one of the information-educational activities for the adolescents. Known also as "Abstinence-Plus" it teaches about abstinence as the best method for avoiding STDs and unintended pregnancy. Also, it teaches about condoms and contraception to reduce the risk of unintended pregnancy and of infection with STDs, including HIV. It also teaches interpersonal and communication skills and helps young people explore their own values, goals, and options. Successful sex education programs were found to:

- Provide accurate information about consequences of STIs and early pregnancy
- Build life skills for interpersonal communication and decision making
- Evidence-based
- Be part of a multipronged approach that also addresses social contexts and structural factors that act against safe sex

Sexuality education can be conducted in schools, health centres, juvenile detention centres, barangays, or in youth-oriented community organizations.

Characteristics of Effective Sex Education Programs

Curriculum development
- Involve people with different backgrounds in theory, research, and sex education
- Plan specified health goals and identified behaviors affecting those goals, risk and protective factors affecting those behaviors, and activities to address those factors
- Assess relevant needs and assets of target group
- Design activities consistent with community values and available resources (e.g., staff skills, staff time, space, supplies)
- Pilot-test curriculum activities

Content of curriculum

- Created safe social environment for youth participants
- Focused on at least one of three health goals—prevention of HIV, of other STIs, and/or of unintended pregnancy
- Focused narrowly on specific sexual behaviors that lead to these health goals (e.g., abstaining from sex, using condoms); gave clear messages about these behaviors; addressed how to avoid situations that might lead to these behaviors
- Targeted several psychosocial risk and protective factors affecting these behaviors (e.g., knowledge, perceived risks, attitudes, perceived norms, self-efficacy)
- Included multiple activities to change each of the targeted risk and protective factor
- Used teaching methods that actively involved youth participants, and helped them to personalize the information
- Made use of activities appropriate to the young people's culture, developmental level, and previous sexual experience
- Addressed topics in a logical order

Curriculum implementation

- Selected educators with desired characteristics, and provided training in curriculum
- Secured at least minimum support from appropriate authorities (e.g., ministry of health, school district, community organization)
- If needed, implemented activities to recruit youth and overcome barriers to their involvement in program
- Implemented virtually all curriculum activities with fidelity

Commission on Population

A. Peer Education Program

Peer educators are adolescents who are trained and capacitated to effect behaviour change among their fellow adolescents. Collectively, peer educators may also effect change at the community level by changing norms and advocating for policies and an environment that is supportive of adolescents. In order to become effective peer educators, these adolescent will need to have capacity building activities on health education and behaviour change advocacy and resource mobilization.

There are many ways to establish a peer education program. As always, start with scanning your environment, who are the most vulnerable adolescents? The "peers" to be chosen should be from these sub-populations. Agree on selection criteria for peer educators. Consult adolescents to help in identifying young people who might be recruited to become peer educators.

Selection criteria for peer educators

- Age within the range of the target population
- Commitment to the goals and objectives of the program
- Ability and willingness to make necessary commitment
- Interest in working with peers and the community
- Tolerant and respectful of others' ideas and behaviors
- Dynamic, motivated, innovative, creative, energetic, questioning and trustworthy

Consult partners with adolescent-focused programs who may already have trained peer educators. There may also be organic groups of adolescents in your community. Identify members of gangs, clans, fraternities, sororities, basketball teams and barkadas who could be influential among their peers and invite them to orientation activities. Recruit and train those adolescents who can serve as role models, health system navigators, sources of information on health issues, and to assist referrals to services. There are several issues to consider for training:

- The trainer chosen should have experience working with youth and empathy for young people. He or she should have a holistic view of sexuality, skills managing groups, and the ability to use a participative methodology.
- The content of the training should reflect both the project's objectives as well as the particular needs of the group. The facilitator should review the pre-test evaluation results in order to adapt or modify the training program accordingly.
- From the outset, establish clear expectations for the peer educators and include discussion of these during the training sessions.
- The education techniques used should change throughout the training in order to maintain the young people's interest and active participation.
- Training sessions should be pedagogical in focus, rather than therapeutic. However, the trainer should be prepared to refer youth who need assistance dealing with personal issues that may arise.
- Emphasize that the confidentiality of training sessions and any conversations the peer educators have as part of their work must be respected completely, even after peer educators leave the program. This is essential to youth feeling comfortable sharing their experiences, feelings and ideas.

Once the training ends, make sure that the youth practice their new knowledge and skills in the community, with the guidance and support of the coordinator or of a more experienced educator. Expect a rapid turnover of peer educators. They go back to school, pursue higher education or find employment. This is a good sign. They have changed from vulnerable youth to productive members of society. Some may continue to volunteer and act as "big sisters" or "big brothers" to younger peer educators. Develop a strategy to keep them interested while continuing to recruit new peer educators.

B. Other Peer Education Strategies of POPCOM

- Sexually Health and Personally Effective– SHAPE Manual
- Teen Trail – U4U
- Video Production on Adolescent and Youth issues

Department of Social Welfare and Development (DSWD)

A. Responsible Parenthood and Proxy Consent

Your program should build the capacity of parents to understand the changes their child is undergoing during the adolescence period, communicate with their adolescent children, increase their comfort with communicating sensitive topics and effectively monitor their adolescent's whereabouts and friends.

The Supreme Court ruling requiring consent for minors availing of contraception presents a dilemma for health service providers. How can one balance complying with the law while respecting the rights of the adolescents? While the option of proxy

consent exists, the Department of Social Welfare and Development (DSWD) assumes legal guardianship if there is suspicion of abuse or any pressing needs in regards with the health conditions of the adolescents for example access to HIV testing.

It also encouraged that when parental consent will be required parents need to be educated regarding the adolescence period, health risks their adolescent might be facing, preventive services available and the law requiring parental consent in accessing FP services and HIV testing by the adolescent.   It should be clear to them that giving consent does not mean giving their blessing for their adolescent to have sex, but merely protecting them from sexually transmitted infections and unintended pregnancy. Giving consent is recognizing that adolescence is a risk-taking stage but those risks can be minimized by effective parenting.

The changes that an adolescent goes through have an impact on parent-child relationships. Physical changes in puberty, expanded logical reasoning, increased idealistic thought, violated expectations, changes in schooling, peers, friendships, dating and movement toward independence contribute to conflicts in parent-adolescent relationships. Studies among Filipino adolescents discovered that adolescents appreciate the house rules implemented by their parents. Absence of rules at home is interpreted as a lack of concern and love for the adolescent. At the same time, adolescents want to carve their own identities and niches. Parents should be capacitated to provide positive supervision, two-way communication and support. They need skills in developing greater parent–child attachment or connectedness, which is best done from an early age; improving parents' supervision and regulation of their children's activities and behaviour; helping parents communicate their values concerning physical, psychosocial and even sexual relationships; and encouraging parents to model the behaviors that they want their children to adopt.

Parenting practices that have been found to promote health include the following:

- Supervision entails parental knowledge of the child's whereabouts, activities, and friends. Supervising results in less antisocial behavior, more parent engagement, adolescent-parent spending more time together and adolescents reporting stronger beliefs on the appropriateness of monitoring. In the Philippine context where overseas employment is common, this necessitates creative approaches in supervising children's activities.

- Communication. Lack of connectedness between parent and adolescent results in feelings of loneliness, impulsivity, depressing and hopelessness among adolescents.
- Parental Support is the provision of venues for the development of the individual's self-concept and self-esteem. Low parental support has been known to increase peer influence among adolescents.

Examination of parent education programs shows that many contain the following training areas:

- Communication skills include two skills: speaking and listening.
- Skills in planning the environment. Many conflicts can be avoided by enriching the child's surroundings to prevent boredom, reduce stimulation, substitute one activity over the other, and planning ahead for changes.
- Parent self-change. One approach to this consists of helping parents understand the stages of child development and relating these stages to parental

expectations.
- Changing the child involves behavior management skills, including clearly defining the inappropriate behavior and the desired behavior, methods of developing and maintaining desirable behavior, and stopping inappropriate behavior.
- Changing the family through family problem solving, beginning with a specific description of the problem, generating alternative solutions, selecting the best solution then implementing and evaluating them.

An overview of the Parent Education Sessions (PES) offered by DSWD and POPCOM's Learning Package can be found in Annex C, Overview of Health Education Modules.

4.7 Resource Mobilization

The implementation of the adolescent health and development program can contribute on the reduction of mortality and morbidity of adolescents. The provision of services and execution of interventions are dependent on the available resources that the national, regional, local and even other institutions can provide. DOH Offices shall provide funds for technical assistance, monitoring, and advocacy. Other government agencies provide counterpart funds to implement AHDP.

A. DOH Central and Regional Assistance

- Provide technical support for strengthening multi-sectoral adolescent policies, and budgeted action plans that operate in several policy domains, such as health, education, employment, environment, and other important determinants.
- Oversee the implementation and movement of funds allocated at the regional and local levels.
- Allocate funds to ensure continuous professional education activities in adolescent health and development at the district level.
- Allocate funds for printing and other dissemination means of decision support tools.

- Allocate funds for capacity building, as part of the continuous professional education of facility managers and health-care providers, in using decision support tools for various adolescent health-care conditions and situations as required by the defined package of services.
- Allocate funds to support the activities necessary to implement the system for supportive supervision in adolescent health care (e.g. training of trainers, travels).

B. Development Partners, NGOs, and Private Sector.

- Conduct mapping of development partners, NGOs, and private sectors in the area.
- Create a team that will help to brainstorm project proposals which can be forwarded to donor community for technical and budgetary support.
- Organize meetings with potential donors to discuss further partnerships.

C. Local Government Units

- As stated in the AO 2013 – 0013, together with health centres, city health offices (CHOs), and provincial health offices (PHOs), they are responsible for designing, funding, implementing, and monitoring local adolescent health and development programs suited for 10 – 19 years old in their area, in partnership with the adolescents, government agencies, civil society organizations, academe, development partners, and private sectors, under the technical guidance of DOH Regional Offices.
- Advocate for local officials to allocate funds for AHDP from their gender and development (GAD) funds.

- Coordinate with other government agencies, and pool resources from them for technical assistance and other financial support.

Section 5

Standards for Quality Adolescent Friendly Health Services

5.1 Delivery of Adolescent-Friendly Health Services

Every adolescent should be able to access a core package of health services, including basic essential health care, pregnancy, delivery and postnatal care; diagnosis and management of sexually-transmitted infections, including HIV. See worksheet 6 for Checklist of Services and Providers.

Services for pregnant adolescents need not be different from care for adult women, but need to be respectful whether the pregnancy occurs within or outside of marriage; anaemia and malnutrition common among adolescents are aggravated by pregnancy and should be treated adequately to prevent early labour and low birth weight. Given that the pregnancy of an adolescent is seen as a high risk pregnancy, antenatal care should be completed and should ensure the presence of a birth plan for a facility based delivery, along with informing the pregnant teen (and parents) regarding contraceptive use as well as breastfeeding. After delivery, the provider should give the necessary postpartum care to detect and manage complications such as haemorrhage and infection; promote breastfeeding and provide contraception to prevent or delay another pregnancy.

Adolescent-friendly health services should be available at the various levels of the health care system and in settings outside the health care system, depending on the capacity of such facilities.

Health services may be delivered in so-called teen centres – separate spaces, either stand-alone or within a health centre or school where adolescents can congregate and receive information and/or services. Teen centres can look different from one locality to the next. Some health units cannot have a room exclusively for adolescents, but there should be a room or sufficient space for privacy and confidentiality that can be used for counselling either adolescents, pregnant women, or other patients. Some just have a corner with a couch or a few chairs and some reading materials on health that adolescents can peruse. Some have video equipment or computers for adolescents' use. Still others have peer or adult counsellors providing their services to adolescents who walk in. The DOH does not prescribe any model or provide a list of equipment needed for a teen centre to be considered adolescent-friendly. This depends on what you need locally. Discuss these with your technical working group as you develop the larger AHDP. What is important is that you comply with the National

The right to health, according to the UN Committee on Economic, Social and Cultural Rights, consists of six normative elements namely health availability, health physical accessibility, health economic accessibility, health information accessibility, health acceptability and health quality. The WHO's criteria for adolescent-friendly health services include services being equitable, affordable, acceptable, adequate, comprehensive, effective, and efficient.

Standards for Adolescent-friendly Services. See Annex for a checklist of these standards.

If you decide to establish a teen centre, adolescents should participate in the decisions on why that facility is needed, where it should be housed, what it should contain, and what activities will be conducted in the teen centre. One way of deciding on these qualities is the Partnership-defined Quality for Youth process.

You may want to form a quality improvement team to plan and implement actions to fill the gaps in quality. This team should have adolescent (10-19 years old) representatives such as peer educators or local youth group members as well as service providers.

The core package shall be made available from health centres or Rural Health Unit (RHU). However, the district, provincial and tertiary level hospitals shall provide services in other areas including substance use, sexual abuse and sexual violence and mental health. They will also cater to clients and patients referred from RHU and Barangay Health Stations (BHS).

Types of settings

- Community-based multi-service facilities may provide health information, education, and livelihood services. It is linked to a health facility.
- Schools may also provide adolescent-friendly health services through the school clinic or by converting an empty room or space into a teen center.
- Pharmacies and stores which sell health products such as condoms, e.g. convenience stores and gas stations
- Outreach services are delivered right where young people congregate, e.g. street corners, sari-sari stores, malls, bars, factories. These could also be temporary mobile clinics that are set up during festivals, family health fairs, and other special events.
- Primary health care facilities are first level care for adolescents. There could also be adolescent spaces or teen centers, within or separate from the health facility, where adolescents can hang out, avail of counseling services, and read or watch educational materials on health.
- Hospitals may be referral centers or also provide adolescent-friendly health services to adolescents coming in for pregnancy or other conditions, such as the Philippine General Hospital model.

Health providers, such as doctors, nurses, and midwives at the above-mentioned health service delivery points shall provide the needed health services. Community-based volunteers, peer educators, psychologists and counsellors, and other staff, e.g. pharmacists, will also provide appropriate services as needed. Collaboration with other facilities, including but not limited to social hygiene clinic, schools, "one-stop-shops", workplace, shopping malls, sports centres, youth hang-outs, will be explored by the government in coordination with non-government and other private institutions.

5.2 Global and National Standards for Adolescent-Friendly Health Services

a. Global Standards for Adolescent Friendly Health Services

Eight global standards were developed by the World Health Organization to define the required level of quality in the delivery of services as shown in the table below. Each standard reflects an important facet of quality services, and in order to meet the needs of adolescents all standards need to be met. This section presents each of these standards and its criteria:

Adolescents' health literacy	**Standard 1**. The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Community support	**Standard 2** The health facility implements systems to ensure that parents, guardians and other community members and community organizations recognize the value of providing health services to adolescents and support such provision and the utilization of services by adolescents
Appropriate package of services	**Standard 3.** The health facility provides a package of information, counselling, diagnostic, a treatment and care service that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach.
Providers' competencies	**Standard 4.** Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.
Facility characteristics	**Standard 5.** The health facility has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the equipment, medicines, supplies and technology needed to ensure effective service provision to adolescents.
Equity and non-discrimination	**Standard 6.** The health facility provides quality services to all adolescents irrespective of their ability to pay, age, sex, marital status, education level, ethnic origin, sexual orientation or other characteristics.
Data and quality improvement	**Standard 7.** The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.
Adolescents' participation	**Standard 8.** Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision.

b. National Standards for Adolescent Friendly Health Services

The Philippines adopts four national standards for the provision of Adolescent-Friendly Health Services. The four quality standards for provision of Adolescent-Friendly Health Services (AFHS) were developed to ensure that adolescents will be able to enjoy a variety of facilities, goods, services and conditions necessary to realize the highest attainable standard of health. These standards are in line with the WHO's criteria for Adolescent-Friendly Health Services, and with the policy documents that exist in the country. These standards will also apply to health services that address the needs of youth.

Standard 1	Adolescents in the catchment area of the facility are aware about the health services it provides and find the health facility easy to reach and obtain services from it.
Standard 2	The services provided by health facilities to adolescents are in line with the accepted package of health services and are provided on site or through referral linkages by well-trained staff effectively.
Standard 3	The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable.
Standard 4	An enabling environment exists in the community for adolescents to seek and utilize the health services that they need and for the health care providers to provide the needed services.

5.3 Levels of Compliance to Standards

As per DOH Department Memorandum 2017-0098, a health facility may be categorized as Level 1, Level 2 or Level 3 depending on its compliance to the National Standards (see Annex for a copy of the Department Memorandum).

A facility is categorized as:

Level 1 Health Facility	If adolescents in the catchment area are aware about the services the health facility provides and finds the health facility easy to reach and to obtain services from it. This means that the facility has the following: • Welcome signage; • Schedule of clinic hours (day and time); • Health services; • Clinical Guidelines in the provision of Adolescent-Friendly Health Services; • Registration logbook containing the list of clients who consulted and were given services; • A designated person with access to the records; and • A designated room/space for client-provider interaction with chairs, tables, well ventilated and well-lighted.
Level 2 Health Facility	In addition to compliance to Level 1 standards, services the health facility provides to adolescents are in line with the accepted package of health services and are provided on-site or referral linkages by well-trained staff effectively. This means that the facility: • Is compliant to the National Standards for Adolescent Service Package; • Has an action plan for information dissemination; • Has a policy regarding flexible time schedule; • Has policies for provision of services; • Has policies for payment schemes; • Has a plan for outreach program and advocacy campaigns; • Has IEC materials on the different programs and services; • Has separate rooms for consultation, treatment and counselling, or at least curtains separating each provider (where conversation between provider and client cannot be heard by others); • Has certificates of training on the minimum training courses prescribed by DOH for adolescent focal persons and other providers; • Has protocols and guidelines for patient-provider interaction; • Has policies and procedure to ensure privacy and confidentiality is posted; • Keep individual records in separate envelopes; • Keep all records in a safe place, preferably in a separate room or a filing cabinet with lock and key; • Has Individual Treatment Record that shows the chief complaint, findings on examination, clinical impression and management of the client; • Has a directory of organizations – name, address, services provided, contact number and contact person (for referral); • Has a referral logbook – name, age, address, Clinical Impression, where referred, reasons for referral, result of referral; • Has referral forms; and • Has an accomplishment report showing the services given at the public health facility as well as those given by other agencies, individuals and peer counselors.
Level 3 Health Facility	In addition to compliance to Level 1 and Level 2 standards, your facility provides health services in ways that respect the rights of adolescents and their privacy and confidentiality; and adolescents find the surroundings and procedures of your facility appealing and acceptable. This means: • Patient flow from admission to delivery of services including the average time for each step is posted in strategic places in your facility; • There are stock cards showing the delivery and utilization of medicines and commodities for adolescent health care; • There is a suggestion box; • There are peer educators assisting in clinic operations and providing services (e.g., lectures, counseling, etc.); • There are materials that can be used by adolescents (educational, sports, musical, etc.); • There is SOP for maintenance of facility; • There is a schedule of meeting of TWG; • There are minutes of meetings of TWG; • There is a designated person with access to the records; • There are leaflets containing the clinic schedule and services which the patient/community members can bring home and share to other community members; • There is an IEC Plan; • There is a copy of the Local Development Plan; • There is an Advocacy Plan; and • There is an Action Plan showing different agency participation.

5.4 Specialized Services to Adolescents

A case management approach can be helpful. One important service that health programs can provide for adolescents currently living in situations of violence or living with HIV is a kind of case management approach. This approach is similar to an approach often used in social work, but DOH suggests that it can be helpful even when used by staff members without professional training. The important thing is that the staff member knows how to help adolescents solve practical problems and how to help them access a range of services in the community. For example, there are staff in all three associations who know the local referral services personally and can talk to women about their legal and social service options with firsthand experience. At one organization in Iloilo City (Family Planning Oganization of the Philippines), a staff member is trained to help adolescent living with HIV plan ways to indentify intervention plans about the client's medications. For example, she knows exactly what couriers do the best job at delivering orders of protection to adolescent key population who are deliberately trying to avoid receiving services. This kind of practical knowledge can be essential for adolescents who are trying to solve difficult problems.

A Sample Summary of the steps and activities, person In-charge, tools and next steps for the provision of Proxy Consent and Case Management Algorithm developed by Department of Health (AHDP, NASPCP, and ROs) Department of Social Welfare and Development, Council for the Welfare of Children, CSOs, City Health Offices, and UNICEF Philippines.

Proxy Consent and Case Management Algorithm

STEPS	ACTIVITY	PERSON IN-CHARGE	TOOL	NEXT STEPS/TARGET OUTPUT
1	Conduct profiling *Note: Case Manager starts from the very start	Peer Educator/ Nurse/ Front line	In-take sheets	SDN referral form (for YKP) standardized
2	Conduct HEEEADSSS Interview	Social Worker /HCP/ Trained HCT Counselor	HEEEADSSS Form A – HIV form for SACCL submission	Harmonized tool Develop Proxy Consent Form standard
3	Proxy Consent and Pre-testing	Social worker Physician	Consent Form Signed either by Registered Social Worker or Medical Doctor	For referral to other services (Conditions apply)
4	Testing	HIV-proficient Medical Technology	Specimen collected/ Reagents	(+) Result Family reintegration process
5	Post Test	Counselor + Social Worker -(should also be HCT trained)/ Doctor (lesser much better)		No CD4 machine, still referring to treatment hub (need to use SDN referral form)
6	Psychosocial Intervention	Social worker + client	DSWD Intake Form	
7	Confirmatory Result (+)	Doctor + Registered Social Worker + Parent guardian + client	CSR	
8	Treatment Initiation [Continuum of Care through the Service Delivery Network]			

Initiation to the Anti-Retroviral Treatment is proposed according to the conditions identified in the following

Preconditions	With Parents/Guardians	Without Parents/Guardians
Asymptomatic	Treatment	Delay or Look for Parents (minimum of 2 weeks up to 1 month)
Symptomatic	Treatment	Discretion of Health Care Providers (HCP)
Children in Need of Special Protection (CNSP) – based on DSWD (as attachment)	N/A Social Workers	Children in Need of Special Protection Protocol
Children in Need of Special Protection (CNSP) – based on DSWD (as attachment)	N/A Social Workers	Children in Need of Special Protection Protocol
Pregnant	Treatment	Treatment
CD4 equal or less than 500	Treatment	Discretion of Physician

Do not overlook or underestimate adolescents' ability to help each other.

The success of the support groups suggests that there is a great, largely untapped potential for adolescents to help each other. For example, Adolescents who have experienced violence of all kinds can be a great resource to one another, both in terms of emotional support and in terms of helping other adolescents to address the practical, legal issues that they face in the attempt to protect themselves from further violence. This suggests that perhaps in the future, health programs in the local government unit (LGU) should explore new ways—in addition to support groups—that survivors of violence can help other adolescents in that situation.

5.5. Adolescent Friendly Health Package of Services

General Health Assessment – History and Physical Exam
Dental Assessment
Psychosocial Risk Assessment and Management
Nutrition Assessment & Counselling
Micronutrient Supplementation
Immunization
Basic Diagnostic Tests
Reproductive Health Assessment and Counselling
Fertility awareness, menstrual health issues, sexual and reproductive health counselling including contraceptive counselling
Pap smear and pelvic exam if sexually active
Adolescent male reproductive health issues
Gender issues (VAWC Desk)
Voluntary Counselling and Testing for STIs and HIV
Risk Assessment (HEEADSSS)
Prevention of Adolescent Pregnancy
Health education sessions
Counselling
Prenatal
History and Physical Examination
Immunization – Tetanus toxoid
Micronutrient supplementation with iron, folate
Laboratory – CBC, blood typing (if not available, refer), pregnancy test, urinalysis
Pregnancy counselling
Nutrition counselling
Birth plan including exclusive breastfeeding counselling
Family planning counselling
HBsAg test for pregnant mothers
Natal (Birthing Homes)
Safe delivery by skilled health worker at a mother-and baby friendly health facility
Essential Newborn Care Protocol
Newborn package:, Vitamin K, Hepatitis B – birth dose, BCG, eye prophylaxis, Newborn Screening
Postnatal
Micronutrient Iron supplementation
Counselling services: Family planning, Nutrition counselling, Exclusive Breastfeeding, Parenting
Provision of FP services and commodities (with parental consent)

Sexually Transmitted Infections/HIV Packages
STI and HIV Risk Assessment
Diagnostics: Gram Stain, RPR, C/S, HIV Counselling and or Testing
Risk Reduction Counselling
Voluntary Counselling and Testing for HIV/STIs
Health Education
Conduct of Adolescent Health sessions among in-school and out of school adolescents
Conduct of Parent Education sessions among parents of adolescents

Building Service Delivery Network
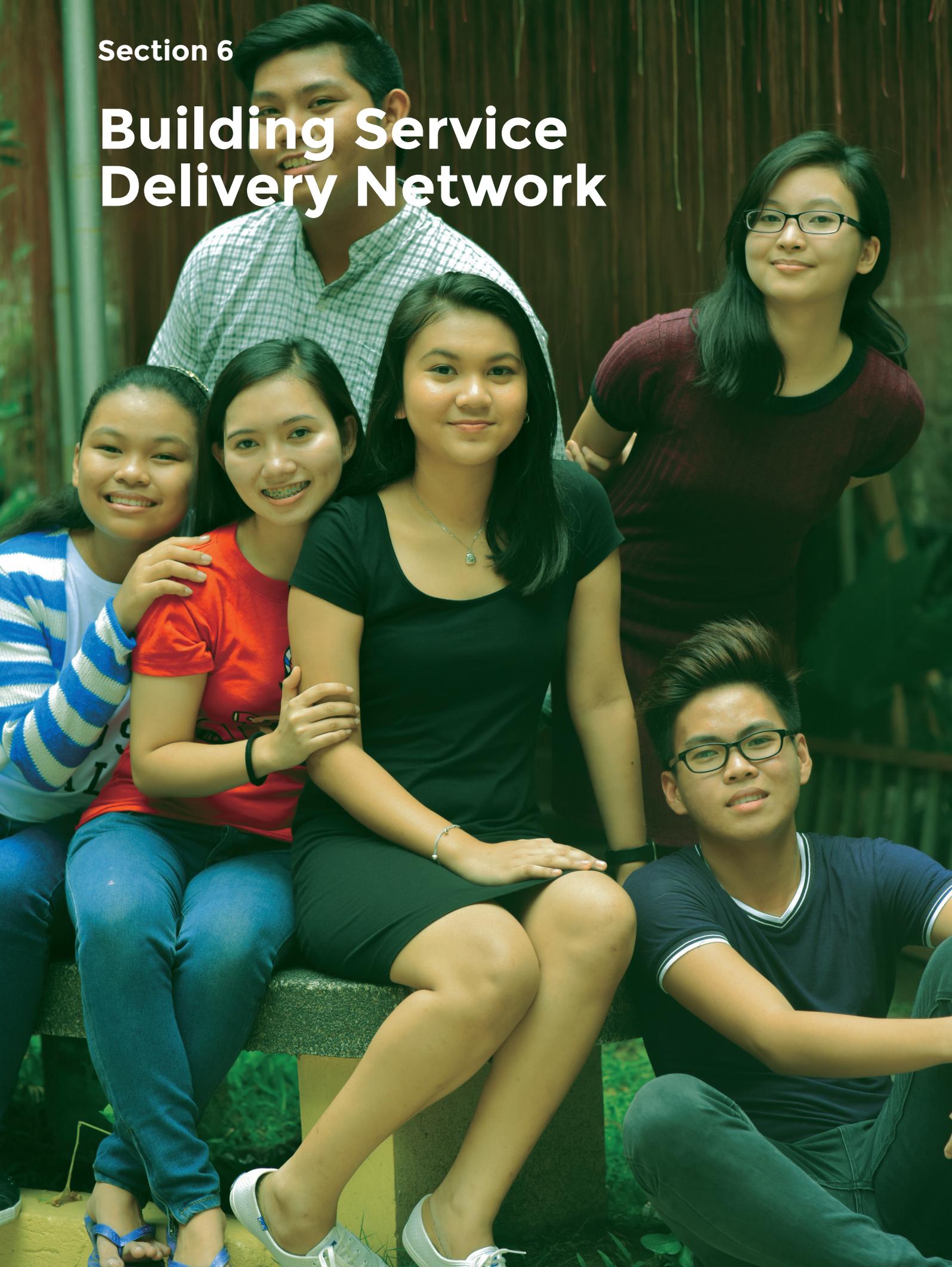
6.1 Service Delivery Network (SDN)

In 2014, to comply with the RPRH Law, the DOH issued Administrative Order 2014-0046 defining the SDN for Universal Health Care and Department Memorandum 2014-0313 adopting the Guidelines in Establishing SDNs. These define an SDN as a network of health facilities and providers within the province or city-wide health systems, offering a core package of health services in an integrated and coordinated manner similar to the local health referral system stipulated under the Local Government Code. However, unlike the health referral system, the SDN is not necessarily confined or limited within geographic or political boundaries of LGUs.

Standard 2 of AFHS mandates health service providers to provide the comprehensive services for adolescents. When this is not possible on site, the health worker should refer the adolescent immediately to a facility or provider that can address the client's needs. Referral algorithms, including consent protocols and flowcharts, should be visibly displayed in the centre. Instituting a service delivery network (SDN) takes advantage of the various services and resources located in separate sites and programs. This synergy makes it possible to provide comprehensive, holistic, and timely care for all adolescents without having to establish new services within the centre.

Building Alliances with Other Agencies or Organizations

DOH established a Technical Working Group (TWG), and built alliances with other organizations working on adolescent health and development at the local and national level. For example: National Youth Commission (NYC), the agency which focuses on adolescents and young people, has been active for years in the TWG. Because of its participation in efforts to raise awareness of the need to address adolescent health and development, National Youth Commission succeeded in ensuring the AHDP is included to all National Policy Guidelines in the country, example of which is the Philippine Youth Development Plan (PYDP).

Joining networks of organizations or establishing Technical Working Groups at the national, regional, or local government units can benefit health programs and allow them to contribute to a broader effort to adolescent health and development program.

In the long run, collaborating with other organizations not only benefits the health program, but also offers a chance for health care organizations to participate in the broader policy debate by raising awareness of gender-based violence as a public health issue.

6.2 Setting up an Service Delivery Network for AHDP

It begins with **identifying the needs of the priority population**, in this case, the most vulnerable adolescents. Follow this with **mapping resources** that are available in your community, including private providers and NGOs. You may have already begun this for Step 1 or 2, when you were deciding team members or when you scanned the environment for your situational analysis. Develop a service directory that contains contact details of the relevant institutions and individuals. **The service directory** should include the names of the organization/individual service provider, address, services available, PhilHealth packages for which the facility are accredited, any fees to be paid, contact person as well as contact details including the telephone numbers, email addresses or websites. Based on this service directory, match the AHDP Core Package of Services with the service providers using Worksheet 6.

As you map various service providers, you may find organizations that don't provide direct services, such as youth advocacy groups, civil society organizations or development partners. After mapping service providers, **negotiate** with the identified service providers if they are willing to accommodate all or part of the demand for that particular service and if they are willing to be part of the SDN. You can then call a meeting with all service providers to agree on **referral protocols** and ways of working. You might want to have service agreements with different providers or a Memorandum of Understanding/ Agreement (MOA) between different programs. See Annex for a sample.

The referral protocol is simple. See Annex for an example. **A referral form** which contains the name of the referring facility and service provider, client's details (name, age, address), history of present condition, physical/laboratory findings if appropriate, name and address of the facility where the client is to be referred, and reason for referral must be in place.

FIGURE 19. Sample Referral

TEENAGE PREGNANCY

SCHOOL

SCHOOL ADVISER

GUIDANCE COUNSELOR

HEALTH CENTER

1. **Adolescent counseling**
2. **Parent counseling**

1. **Confirmation of Pregnancy**
2. **Physical Assessment**
3. **Counselling/HX. Educ.**
4. **Prenatal/schedule**

HOSPITAL
• **Delivery**
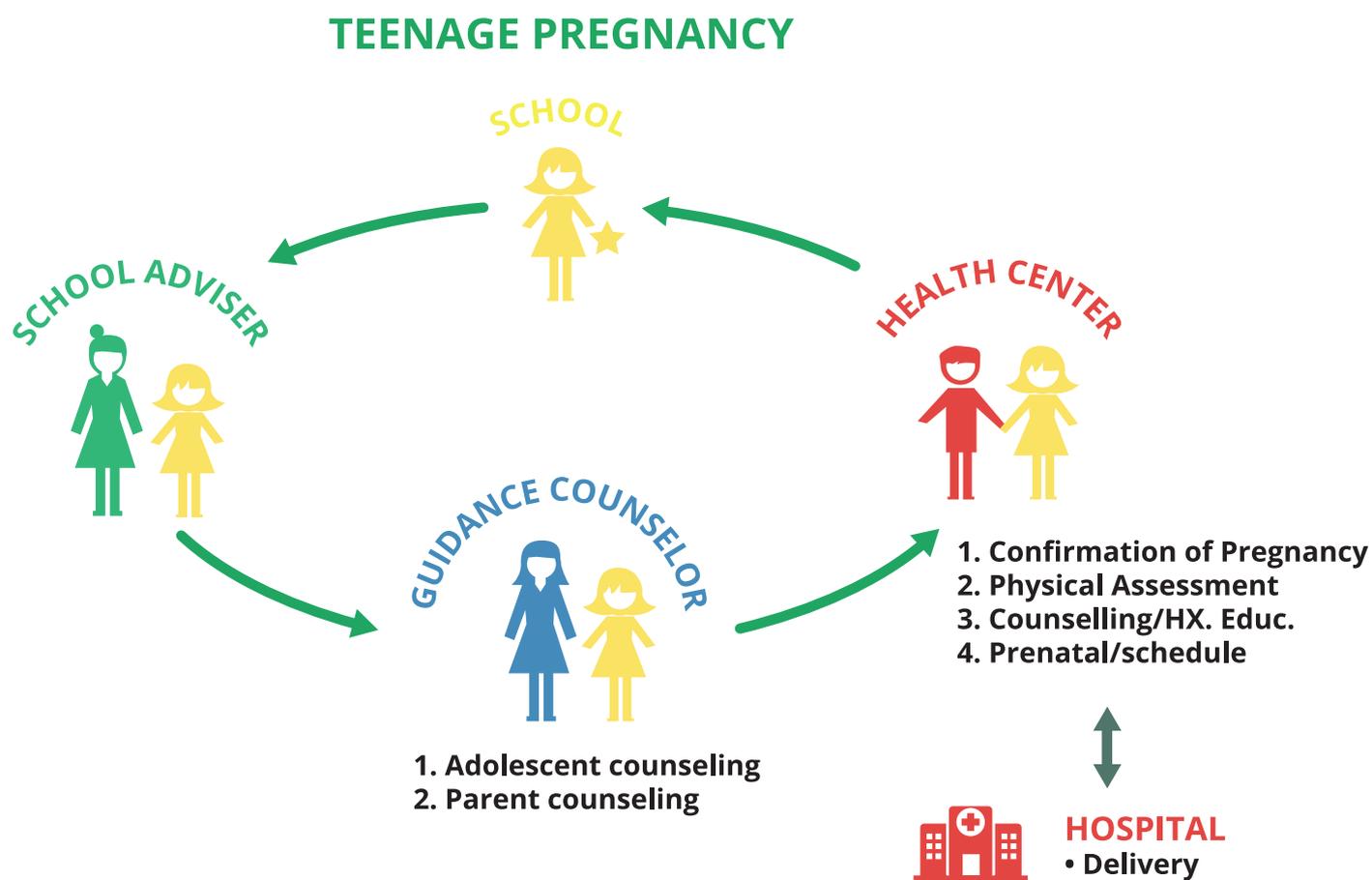
A **return referral form** should be present and the client be instructed to bring this back to the referring facility. The referral form should be sealed in envelope and addressed to the service provider of the facility to which the client is being referred to. All referrals made and their outcome should be listed in a referral logbook that should be maintained at the facility.

You should also establish a **transport and communication** system to link adolescents to the facility. A client-oriented referral system should ensure that the adolescent client will be able to reach the facility, receive the needed services and follow-up actions are complied with. Ask the community or barangay how they can support the SDN with these support services.

The MHO/CHO should **collect and consolidate reports** on the coverage of service utilization from the health centre/ RHU/ BHS on a monthly basis in order to monitor the progress of the SDN. Your TWG should meet quarterly to assess the caseloads of the designated facilities following increasing demands from adolescents. Discuss if there is a need to conduct client feedback through a survey; provide additional human resources, trainings, equipment or facility upgrading to accommodate additional caseloads in the facility; engage additional health providers from the private sector; or delist designated facilities who were found not providing adolescent-friendly services.

6.3 Suggested Steps for Developing a Referral Directory

Despite all of these problems, health programs have an obligation to find out what services do exist in their communities. Furthermore, identifying existing services in the area can help avoid duplication of efforts and can determine which services are most needed in the community.

Health programs need to begin by researching what does exist in the community.

It often takes time and effort to find out what services exist in a community, and many health programs simply have not invested the resources in finding out what services do exist for survivors. But health programs may find more existing services than they expect. When a community lacks nongovernmental organizations exclusively dedicated to the needs of adolescents, then health programs may need to look at other public and private institutions whose services might be useful to them, even though they may not be designed exclusively for that purpose.

Putting this information into a referral directory is a basic step in the effort to provide external referrals to survivors of violence.

Once health programs have gathered information on local services, this information should be compiled into a referral directory and made available to all staff, either by distributing copies to all health care providers or by ensuring that at least one copy is available in a convenient place in each health clinic. Creating a directory of local insti tutions to which providers can refer clients can be done with minimal resources. The directory can be developed either by staff members or by external consultants. The rest of this section provides some tools for developing a directory of referral services in the surrounding community, including a five-step guide, a sample interview guide, and a sample format for a referral directory page.11

SUGGESTED STEPS FOR DEVELOPING A REFERRAL DIRECTORY
(adapted and revised from IPPF/WHR Tools)

Step 1	**Determine the geographic area to be included in the referral network.** Where do most of your clients live? How far can they travel to seek services? If the institution has clinics, health centres, or BHS, in several parts of the barangay, municipality or city each site may need a different directory to ensure that the services are geographically accessible to adolescents.
Step 2	**Identify institutions in the area that provide services that are relevant for adolescents.** This list can include medical, psychological, social and legal organizations, as well as local police contacts. You may also want to consider including institutions that address issues on nutrition, HIV and AIDS, mental health, alcohol and drug abuse, as well as those that offer services for adolescents who have experienced or have been exposed to violence. Each institution may be able to name other local institutions that can be included in the directory.
Step 3	**Call or (ideally) visit each institution to gather key information about its services.** To ensure that you gather up-to-date information about each institution, and to have the opportunity to see the services firsthand, it is best to conduct a brief, informal interview in person with a staff member from the organization where services are provided. After describing your own work in the area of adolescent health, you should ask a series of key questions to identify whether and how the institution can be used for referrals. On the following page is a brief interview guide and format for presenting the information.
Step 4	**Organize the information into a directory.** You can organize information about referral institutions in different ways (for example, by location, type of service offered, etc.). If the number of referral services available in the community is small, then the directory may be very concise. If the directory is long, an index of institutions by name and type of service can make a directory more user-friendly.
Step 5	**Distribute the directory among health care providers.** Ideally, a health program should distribute a copy of the directory to each health care provider so that all staff members who interact with clients have access to this information. If resource constraints make it difficult to print this many copies, then every clinic should have a directory available to staff in a convenient, accessible place.
Step 6	**Gather feedback from providers about how well the directory is working.** Managers should take the time to discuss the directory with providers soon after it is introduced to make sure that the format is workable and that the providers have not had any difficulties with the process of making referrals. Once providers have used the directory for a period of time, they may know what referral services are or are not in fact accessible to their clients, for example.
Step 7	**Formalize relationships with referral institutions.** After creating a directory, the next step is to create more formal partnerships with other agencies. This may include setting up formal referral and counter-referral systems, as well as collaborating on projects. In some cases, some organizations have negotiated free to discounted prices for their clients most especially with adolescents. Ideally, organizations involved in a referral network should be in contact with one another on a regular basis to give feedback, stay up-todate, and provide at least minimal follow-up to selected cases and other issues related to this work.
Step 8	**Update the information in the directory on a regular basis.** It is essential for health programs to update the information in the directory on a regular basis (for example, every six months) to avoid giving adolescents misinformation. Not only can misinformation waste adolescents' time, money and energy, but it can also put them at risk in a number of ways. Remember that services can close, relocate, raise their costs, or change their procedures, especially in resource-poor settings where funding is scarce.

BRIEF INTERVIEW GUIDE FOR DEVELOPING A REFERRAL DIRECTORY	
First, gather practical information, such as:	*Then ask more specific questions about the types of services available for adolescents, for example:*
• What is the full name and acronym of the institution? • What is the contact information (address, phone numbers, fax, email, etc.)? • What is the name and title of the director of the organization? • What is the name and title of the person providing information? • What types of services are available at this organization? • What are the hours of operation? • What is the process by which clients can obtain services? For example, is an appointment required? • Can clients get service by dropping in during open hours? • What is the cost of services?	Do you currently provide services designed specifically for adolescent health services? • If so, what types of services do you address? • Do you have any information about the profile of adolescents whom you serve? • If your organization does not specifically offer services for adolescents what services do you offer that might be useful to them in that situation? • Do you provide direct services or do you primarily refer adolescents to other organizations? To what other organizations do you refer clients? • What criteria do you use for making referrals? • Do you have any formal referral arrangements with other organizations? If so, how do they work? • What other activities does your organization • undertake to address the issue of adolescent health (e.g. research, advocacy, educational campaigns, sensitization, training, production of materials, etc.)? • Do you have educational or informational materials about adolescents that you would be willing to share with other organizations working on these issues? • Do you know of other institutions in this area that provide services that could be helpful for adolescent health? • Is your organization a member of any networks of organizations that work on the issue of adolescents?

SAMPLE FORMAT FOR A DIRECTORY OF REFERRAL ORGANIZATIONS	
CONTACT INFORMATION	
Full Name of the Office	Department of Health
Acronym	DOH
Type of Institution	Government / Public
Address	Tayuman, Manila
Telephone	911-11-11
Fax	922-22-22
Email	dohahdp@gmail.com
Name of the Head and Position	MINERVA KITONG , MD
Date Information Updated/Filled-up	DIRECTOR, BUREAU OF ADOLESCENT HEALTH AND DEVELOPMENT
Brief information of your office, agency, or organization	June 17, 2017

DESCRIPTION OF SERVICES RELATED TO ADOLESCENT HEALTH	
Characteristics of the population served:	10 – 19 years old General Population YKPs
Types of services:	Counselling
Opening Hours:	24/7
Do you ask for parental consent and informed if minor?	Inform consent Parental consent
Costs of Services	Free
Where do you refer? Which organizations or offices?	POPCOM, DSWD, Hospitals
Type of staff who provide services to adolescent health	General Practitioner, OB-GYNE, Paediatricians, Psychologist
Other activities related to adolescent health services	Peer Education Counselling Focus Group Discussion

Program Monitoring and Reporting

7.1 Importance of Monitoring and Evaluating (M&E)

A commitment to monitoring and evaluation is an essential component of quality care, and perhaps what DOH AHDP would like to strengthen more. Together with the DOH - Epidemiology Bureau M & E initiative was designed to foster collaboration at the national and regional levels between other health program components, and at the local level staff with expertise in managing programs and staff with expertise in evaluation, and the planners devoted a substantial portion of effort to monitoring the progress and evaluating the results of the associations' work. This collaboration not only allowed the initiative to produce the tools and lessons learned documented in this manual, but just as important, and hopefully it allowed DOH to ensure that the changes they made to their services will be feasible and acceptable to both providers and clients.

Health programs can take a variety of approaches to monitoring and evaluation and research at different points in time, including formal and informal, qualitative and quantitative. Research can be used to understand emerging or persistent issues, select appropriate interventions and advocate for budget allocation or resource mobilization. Start by determining gaps in information, observing emerging issues or looking at the effectiveness of your program. You can partner with the academe, research institutions, and students with similar interests in adolescent health and development.

Monitoring and Evaluating Quality

TABLE 5. Examples of different approaches to monitoring and evaluation[11]

Approach	Examples of Methods
Formal evaluations by external consultants at baseline, midterm and follow-up	Surveys using structured questionnaires Discussion groups with providers and clients Random record reviews Clinic observations In-depth interviews with key informants
Small-scale case studies to evaluate new policies or tools	Routine service statistics Focus groups with staff Focus groups with clients Client Exit Interview
Information systems to collect systematic service data	Routine service statistics on key indicators
Regular meetings with staff to discuss new policies and tools	Informal discussions and dialogue among frontline staff and Managers
Individual efforts of managers to track the progress of needed reforms in the organization	Checklists Strategic plans Personal observation
Individual efforts of managers to monitor the morale and performance of staff	Routine service statistics Informal reviews of medical records Informal discussions with staff members
Pre- and post-tests of providers' knowledge and skills before and after training	Questionnaires Role-plays Informal group discussions

Collecting baseline data is essential for measuring change over time.

As previously discussed, baseline data is essential because health managers can only measure change if they have a point of comparison. Baseline data and follow-up data collection should be a part of any effort to strengthen the health care response to adolescent health.

Changes in knowledge can be measured immediately, but changes in attitudes take time.

Improving providers' attitudes and beliefs is an essential component of strengthening the health care response to adolescent health services. However, while knowledge can change quickly, attitudes about dealing with adolescents often take years to change. Managers can measure changes in knowledge immediately after a staff training, but measuring changes in attitudes may require a long-term approach.

Efforts to plan, monitor and evaluate improvements in quality of care must include the participation of staff.

Managers need to involve staff in evaluating the acceptability and the effectiveness of new policies and tools. Their perspectives are the most important part of understanding whether a new policy is working and whether it needs to be adjusted. These perspectives can be measured through formal methods, such as focus groups, or informal methods, such as regular staff meetings or informal discussions with staff.

Progress in the program towards your targets can only be done in the presence of a purposive system of gathering and accessing reliable, accurate, and timely information for programming decisions; policy development or changes. The program matrix earlier introduced should contain indicators that have available sources of data. As a first step, the facility disaggregates data by age and sex with regard to client accessing services.

M&E activities at the local level can consist of data collection and analysis using existing data, annual program review and quarterly SDN meetings should be included in the annual plan with the accompanying budget. Data can also be extracted from other agencies when applicable. It is also important, when partnering, to agree on data reporting flows and protocols between and among agencies.

Annex lists and defines some key outcome and output indicators to be monitored for the AHDP. National or regional figures and sources of data can be referred to when comparing with similar local data. Another option is to look into trends across time as the AHDP is being implemented based on the indicators. Use the status or trends of the indicators to make program decisions in your locality.

7.2 Scope and Limitations

The AHDP Monitoring and Evaluation (M&E) plan contains the M&E framework, indicators, data sources and flow of reporting. The indicators listed in this M&E plan only consists of impact and outcome indicators. The output indicators are component program-specific and should be available in the individual M&E plan of each component program.

Moreover, since there is a wide range of data sources for baseline data, each data source will be described briefly but links are provided for more in-depth information or the latest available report.

It should also be emphasized that while this document attempts to cover all component programs of the AHDP, this is considered a living document to allow for updating of indicators, baselines, and targets from the different component programs.

7.3 AHDP Monitoring and Evaluation (M&E) framework

The vision of the AHDP, as indicated in AO 2013-0013 is to have well-informed, empowered, responsible and healthy adolescents who are leaders in society. In line with this, the impact of the adolescent health program of the Department of Health (DOH) is to improve the health status of adolescents. This can be achieved through the expected outcomes including increase in knowledge, avoidance of risky behaviors, practice of protective behaviors, and utlization of services. The various activities that will be conducted by AHDP and other component programs have several expected outputs. For AHDP, the outputs may be divided into seven categories.
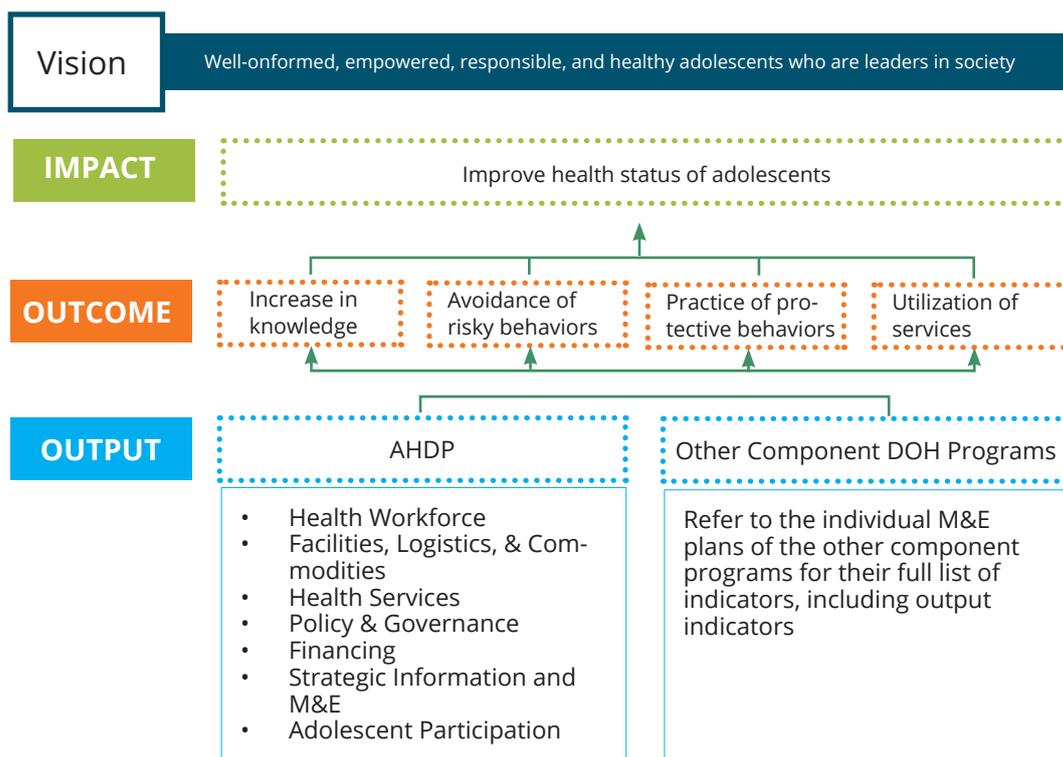
7.4 Program Indicators

In order to deliver adolescent-friendly health services to this age group, the Adolescent Health and Development Program (AHDP) is focusing on the different building blocks of the health system which are:

- health workforce
- facilities, logistics, and commodities
- services
- financing
- policy and governance
- strategic information and monitoring and evaluation (M&E)

Moreover, a focus on adolescent participation is also highlighted to ensure that adolescents are not only beneficiaries but are also partners and leaders in the different adolescent health programs. The indicators for AHDP is listed in Table 6.

TABLE 6. AHDP Indicators

#	Categories	Indicator	Disaggregation	Source	Baseline (2016)	Target	
						2020	2022
1	Health workforce	Number of health personnel trained in providing adolescent-friendly health services a. Adolescent Job Aide (AJA) b. Adolescent Health Education and Practical Training (ADEPT)	Type of health personnel (doctor, nurse, midwife, peer educator)	Regional AHDP reports			
2	Health workforce	Number of people trained in the use of Health Young Ones a. Health care workers b. Adolescents c.Others	Type of people trained	Regional AHDP reports			
3	Adolescent Participation	Number of adolescents with capacity to provide health information, life skills training, and referral	By age and sex	Regional AHDP reports			
4	Adolescent Participation	Number of health facilities with youth volunteers	Type of facilities (Rural Health Units or RHU, DOH-retained hospitals, teen centers, others)	Regional AHDP reports			
5	Facilities, logistics & commidities	Percentage of adolescent-friendly health facilities (AFHF) N: # of facilities (RHU and hospitals) that have Level 1, Level 2, or Level 3 AFHF certification D: Total # of facilities (RHU and DOH-retained hospitals)	Level of certification (Level 1, 2, 3) Type of facilities (RHU, DOH-retained hospitals, teen centers, others)	Regional AHDP reports			

6	Services	Number of people given information on adolescent health (through Health Young Ones) a. adolescents b. parents c. others	Type of clients (adolescents, parents, health care providers) By age and sex	Regional AHDP reports			
7	Services	Number of adolescents assessed using HEEEADSSSS(Home, Education, Employment, Eating habits, Activities, Drugs, Sexuality, Safety, Spirituality, Suicide)tool	By age and sex	Regional AHDP reports			
8	Services	Percentage of adolescents referred to appropriate services among those with health risk N: # of adolescents referred to appropriate services D: # of adolescents with health risk	By age and sex	Regional AHDP reports			
8.1	Services	Number of adolescents who went to the facility to access services among those referred through HEEEADSSSS	By age and sex	Regional AHDP reports			
9	Financing	Total expenditure per year of the regional AHDP	-	Regional AHDP reports			
10	Policy & Governance	Percentage of regions with service delivery networks that includes adolescents N: # of regions with service delivery networks that includes adolescents D: Total # of regions	-	Regional AHDP reports			
11	Policy & Governance	Number of policies that promote adolescent health and their access to services	By component program	DOH records review; Regional AHDP reports			
12	Strategic information and M&E	Percentage of regions with sex- and age-disaggregated data, specifically on adolescents 10-19 years old N: # of regions that submits sex- and age-disaggregated data for adolescent health D: Total # of regions	-	Regional AHDP reports			

*Report only when available

To monitor the progress of the AHDP program, an annual scorecard will be updated at the regional and national levels (see Table 7). This scorecard will help the national AHDP to review program implementation and reassess priorities as needed

ADOLESCENT HEALTH AND DEVELOPMENT PROGRAM: *Regional Monitoring Tool*

Health and non-health workforce

#	Indicator	Male	Female	Total
1.1	# of personnel trained in AJA			
a	Doctor			
b	Nurse			
c	Midwife			
d	Peer educator			
e	Others (e.g. teachers, RSW)			
1.2	# of personnel trained in ADEPT			
a	Doctor			
b	Nurse			
c	Midwife			
d	Peer educator			
e	Others (e.g. teachers, RSW)			
2	# of people trained in the use of Health Young Ones			
a	Health care providers			
b	Adolescents			
c	Others (e.g. teachers, RSW)			

Facilities, Logistics, and Commodities

#	Indicator	Total # of facility	Level 1 #	Level 1 %	Level 2 #	Level 2 %	Level 3 #	Level 3 %
5	% of AF-HF							
a	CHO							
b	RHU							
c	DOH-retained hospital							
d	Teen centers							
	i. School							
	ii. Community							
e	Others							

Adolescent Participation

#	Indicator	Male	Female	Total
3	# of adolescents with capacity to provide health information, life skills training, and referral			
a	10-14			
b	15-19			
4	Number of health facilities with adolescent volunteers		By type of facility	
a	RHU			
b	Teen centers			
	i. School			
	ii. Community			
c	Others			

Services

#	Indicator	Male 10-14	Male 15-19	Female 10-14	Female 15-19	Total
6	# of people given information using HYO					
a	Adolescents					
b	Parents (all ages)					
c	Health care providers (all ages)					
7	# of adolescents assessed using HEEEADSSSS tool					
8	% adolescents referred to appropriate services among those with health risk					
a	N: # referred to appropriate services					
b	D: # of adolescents with health risk					
8.1	# of adolescents who went to the facility to access services among those referred through HEADSS					

Financing, Policy, and M&E

#	Indicator	
9	Total expenditure per year of the regional AHDP	Php _____
10	Service Delivery Network for adolescents available?	Yes ___ No ___
a	Regional	
b	Local (LGU)	LGUs with SDN: _____ Total # of LGUs: _____
11	# of policies that promote adolescent health and their access to services	# of Policies: _____
12	Sex- and age-disaggregated data, specifically on adolescents 10-19 years old available?	Yes ___ No ___

ANNUAL SCORECARD A: Adolescent Health Program Indicators

#	Health systems indicators	National Baseline	National 2018	R1	R2	R3	R4A	R4B	R5	R6	R7	R8	R9	R10	R11	R12	NCR	CAR	CAR-AGA	ARMM
1a	# AJA-trained																			
1b	# ADEPT-trained																			
2a	# HYO-trained HCP																			
2b	# HYO-trained adolescents																			
3	% AFHF																			
4	# capacitated adolescents																			
5	# facilities with adolescent volunteers																			
6a	# adolescents given HYO																			
6b	# parents given HYO																			
6c	# HCPs given HYO																			
7	# assessed using HEADS																			
8	% adolescents referred																			
8.1	# adolescents went to HF																			
9	Total expenditure																			
10	% regions with adolescent SDN																			
	a. Regional																			
	b. Local (LGU)																			
11	# of policies for adolescent health																			
12	% regions w sex- & age- disagg. Data																			

7.5 Component Program Indicators: MORBIDITIES, MORTALITIES, AND RISK FACTORS

Aside from the AHDP setting the health system building blocks, the different component programs (shown in Figure 1) of the AHDP are also expected to have strategies and targets specific for adolescents. As an example, while the Nutrition program targets all ages, there should be priority interventions for adolescents to address the specific issues of this population. This is true for all other component programs of the AHDP.

While each component program has their own monitoring and evaluation (M&E) plan and core indicators, stakeholders have been asked to identify key indicators in relation to their priorities for adolescents. The impact indicators (i.e. mortalities, morbidities) are listed in Table 4.

TABLE 8. Impact indicators per component program (mortalities and morbidities)

#	Categories	Indicator	Source (frequency)	Baseline (Year)	Target	
					2020	**2022**
1	Nutrition	Prevalence of overweight/obesity among adolescents N: # of adolescents surveyed who are overweight or obese (based on guidelines) D: # of adolescents surveyed	NNS (every 5 years	All: 8.3% (2013)		
2	Nutrition	Prevalence of wasting among adolescents N: # of adolescents surveyed who are wasted (based on guidelines) D: # of adolescents surveyed	NNS (every 5 years)	All: 12.4% M: 15% (2013)		
3	Nutrition	Prevalence of anemia among adolescents N: # of adolescents surveyed who are anemic (based on guidelines) D: # of adolescents surveyed	NS (every 5 years)	M 13-19 yo: 5.3% F 13-19 yo: 10.2% (2013)		
3.1	Nutrition	Reported cases of anemia	DOH Program Data (annually)	No baseline data		
4	Family planning	Adolescent birth rate N: # of births to women ages 15–19 D: # of adolescents 15-19 X 1,000	NDHS (every 5 years)	57.1 in 1,000 girls 15-19 yo (2013)		
5	Family planning	Percentage of adolescents who have begun childbearing	NDHS (every 5 years)	15-19 yo: 20% (2013)		
5.1	Family planning	Reported cases of teenage pregnancy	FHSIS (annually)	No baseline data		
6	Safe motherhood	Proportion of adolescent girls who die due to maternal causes N: # of adoelescent girls who die due to maternal causes D: # of adolescents girls who gave birth in a given year x 100,000	CRVS (annually)	128 in 100,000 girls 15-19 yo (2012)		
6.1	Safe motherhood	Reported cases of maternal deaths	BDOH Program Data (annually)	No baseline data		

7	HIV & STI	STI prevalence among adolescent key populations N: # of adolescent key populations with syphilis D: # of adolesent key population surveyed	IHBSS (every 2-3 years)	MSM 15-19 yo: 0.82% *Sentinel sites: 0.86% (2015) FSW 15-19 yo: 0.97% PWID Male 15-19 yo: 0%, PWID Female 15-19 yo: 0% (2015)		
7.1	HIV & STI	Reported cases of gonorrhea among adolescents	LABSS (annually)	No baseline data		
8	HIV & STI	HIV prevalence among adolescent key populations N: # of adolescent key populations with HIV D: # of adolescent key population surveyed	IHBSS (every 2-3 years)	MSM 15-19 yo: 1.57% (among all); 2.18% (among those who ever had anal sex) *Sentinel sites: 2.45% (among all) 3.35% (among those who ever had anal sex) FSW 15-19 yo: 0.14% (2013) PWID Male 15-19 yo: 1.1% *Sentinel site: 3.4% (2015) PWID Female 15-19 yo: 16.7% (2015)		
8.1	HIV & STI	Newly diagnosed cases of HIV among adolescents	HARP (annually)	384 adolescents (2016)		
9	HIV & STI	Hepatitis B prevalence among adolescent key populations N: # of adolescent key populations with HIV D: # of adolescent key population surveyed	IHBSS (every 2-3 years)	PWID Male 15-19 yo: 6.3% *Sentinel site: 11.2% (2015) PWID Female 15-19 yo: 0% (2015) (2013)		
10	HIV & STI	AIDS-related deaths among adolescents	HARP (annually)	3 adolescents (2016)		
11	Oral Health	Proportion of adolescents with dental caries	National Survey on Oral Health and Nutritional Status	6-12 yo: 92.3% (2005)		
11.1	Oral Health	Reported cases of dental caries	School records?	No baseline data		
12	Oral Health	Proportion of adolescents with periodontitis	DOH Program Data (annually)	No baseline data		

13	EPI/VPD	Number of adolescents with measles	PIDSR (annually)	12 adolescents (2016)		
14	EPI/VPD	Number of adolescents with rubella	PIDSR (annually)	60 adolescents (2016)		
15	EPI/VPD	Number of adolescents with tetanus	PIDSR (annually)	120 adolescents (2016)		
16	EPI/VPD	Number of adolescents with diphtheria	PIDSR (annually)	20 adolescents (2016)		
17	Mental Health	Proportion of adolescents who attempted suicide N: # of adolescents reported to attempt suicide D: # of adolescents surveyed	YAFSS (every 5 years)	All 15-24: 3.2% M: 1.5% F: 4.8% (2013)		
17.1	Mental Health	Reported cases of attempted suicide	DOH Program Data (annually)	No baseline data		
18	Mental Health	Number of adolescents who died due to suicide	CRVS (annually)	337 (2012)		
19	Injury	Reported cases of road traffic accidents among adolescents	ONEISS (annually)	All: 2,102 M: 1,454 F: 648 (Q2 2016)		
20	Injury	Reported cases of drowning among adolescents	ONEISS (annually)	All: 7 Male: 2 Female: 5 (Q2 2016)		
21	Violence	Proportion of adolescents who died due to interpersonal violence	CRVS (annually)			
22	Violence	Proportion of adolescents who experienced physical violence	NDHS	Female 15-19yo: 310		
22.1	Violence	Reported cases of physical violence among adolescents	VAWCRS	No baseline data		
23	Violence	Proportion of adolescents who experienced sexual violence	NDHS	Female 15-19yo: 44		
23.1	Violence	Reported cases of sexual violence among adolescents	VAWCRS	No baseline data		

Aside from the component programs, there are risk factors that concern adolescents. Abuse of substances including alcohol, drugs, and tobacco may lead to other morbidities or mortalities. Table 9 lists the indicators concerning substance abuse among adolescents.

TABLE 9. Risk factors indicators

#	Categories	Indicator	Source (frequency)	Baseline (Year)	Target 2020	Target 2022
24	Alcohol	Percentage of adolescents who are binge drinkers N: # of binge drinkers among adolescents (based on guidelines) D: # of adolescent surveyed	GSHS School-based survey (bi-annually)	All 13-15: 15.5% (2013)		
25	Drugs	Percentage of adolescents who are currently taking dangerous drugs N: # of drug users among adolescents D: # of adolescents surveyed	YAFSS, School-based survey (bi-annually)	All 15-24: 4% M: 7.1% F: 0.8% (2013)		
26	Tobacco Use	Percentage of adolescents who are current tobacco users N: # of current tobacco users among adolescents D: # of all adolescents surveyed	NNC, GYTS, YAFSS	All 10-19: 5.5%(2015 NNC) All 13-15: 13.7% (2011 GYTS) All 15-24: All 15-24: 19.7% (2013 YAFSS)		

The indicators listed in table 8 and 9 is an exhaustive list of the key indicators needed to monitor and evaluate the AHDP. However, some of these indicators are dependent on national surveys that are not regularly conducted (e.g. every 3-5 years).

To monitor the progress of these impact indicators more regularly, an annual scorecard will be updated at the regional and national levels (see Table 10). This scorecard will focus on selected indicators on morbidities, mortalities, and risks factors. This can provide an annual snapshot on where the AHDP is lagging or performing well, and can be the basis of prioritization for the succeeding years.

Data will be disaggregated further by sex (male and female) and by age (10-14 and 15-19 years old). However, there is a need to distinguish between minors and the older adolescents for some indicators. In this case, the disaggregation will be 10-14,15-17 and 18-19 years old.

TABLE 10. Annual Scorecard B: Morbities, Mortalities, and Risk Factors

#	Cases among adolescents, 10-19	National Baseline 2018	R1	R2	R3	R4A	R4B	R5	R6	R7	R8	R9	R10	R11	R12	NCR	CAR	CAR-AGA	ARMM

ANNUAL SCORECARD B: Morbidities, Mortalities, and Risk factors

#	Cases among adolescents, 10-19	National Baseline 2018	R1	R2	R3	R4A	R4B	R5	R6	R7	R8	R9	R10	R11	R12	NCR	CAR	CAR-AGA	ARMM
1	Anemia																		
2	dental caries																		
3	teenage pregnancy																		
4	Adolescent maternal deaths																		
5	Sexually Transmitted Infections(e.g.Gonorrhoea, Syphillis,etc)																		
6	HIV																		
7	Rubella																		
8	Tetanus																		
9	attempted suicide																		
10	road traffic accidents																		
11	Drowning																		
12	physical violence																		
13	sexual violence																		
14	% of binge drinkers*																		
15	% of current tobacco users*																		
16	regular drug users or drug dependents																		

Outcome indicators: KNOWLEDGE AND BEHAVIOR
Knowledge Indicators

The definition for the knowledge indicators listed below are not yet complete. These indicators are being developed further in coordination with other partners, especially the Department of Education. However, it is important to ensure that there is a clear definition and means of verification for all these knowledge indicators.

TABLE 11. Knowledge indicators

#	indicator	Definition	Source (frequency)	Baseline (Year)	Target 2020	Target 2022
1	Percentage of adolescents with correct knowledge on: N: # of adolescents answering the standard knowledge items* correctly D: # of adolescents surveyed		School-based survey**			
25	a. ,Nutrition	Correctly selects which food items fall in the green, yellow, and red food categories of the Department of Education	**			
26	b. Family planning		**			
	c. Teenage pregnancy		**			
	d. HIV	Correctly answers the five basic HIV transmission and prevention questions: 1. A health looking person can have HIV 2. Having one, faithful, uninfected partner prevents HIV infection 3. HIV cannot be transmitted through toilet bowls 4. HIV cannot be transmitted through mosquito bites 5. HIV transmission can be prevented by using condoms	**, IHBSS, YAFSS	MSM 15-19 yo: 33.45% FSW 15-19 yo: 20.45% PWID Female 15-19yo: 29.66% PWID Male 15-19 yo: 66.67% (2015 IHBSS) 15-19 yo: 14.5% (YAFSS)	90%	
	e. Oral health		**			
	f. Vaccination		**			
	g. Injury	Correctly identifies the following as ways of preventing road traffic accidents 1. Looking left and right when crossing the streets 2. Use of helmet 3. Use of seatbelt	**			

#	indicator	Definition	Source (frequency)	Baseline (Year)	Target	
					2020	2022
	h. Violence	1. Correctly identifies warning signs of violence (others and self) 2. Correctly identifies where to access protective services	**			
	i. Mental health		**			
	j. Smoking		**, GYTS			
	k. Alcohol		**			
	l. Drugs	Correctly identifies the following: 1. Ill effects of using drugs 2. How to prevent drug addiction 3. How to access services	**			
	e. Oral health		**			
	f. Vaccination		**			
	g. Injury	Correctly identifies the following as ways of preventing road traffic accidents 1. Looking left and right when crossing the streets 2. Use of helmet 3. Use of seatbelt	**			

** All of the knowledge items will be included in the school-based survey.

Behavioral Indicators

TABLE 12. Behavioral indicators

#	Component	Indicator	Source (frequency)	Baseline (Year)	Target 2020	Target 2022
1	Nutrition (R)	Percentage of adolescents who consumed sugar-sweetened beverages at least twice a week N: # of adolescents who consumed sugar sweetened beverages (i.e. soda or powdered/ bottled juice) at least twice a week D: # of adolescents surveyed	YAFSS	15-19 yo: 52.6% (2013)		
2	Nutrition (R)	Percentage of adolescents with a sedentary lifestyle N: # of adolescents who spend atleast 5 hours a day without moving D: # of adolescents surveyed	YAFSS	15-19 yo: 29.9% (2013)		
3	Nutrition (R)	Percentage of adolescents who skip breakfast N: # of adolescents who skipped breakfast atleast xxx times a week D: # of adolescents surveyed				
4	Nutrition (S)	Percentage of adolescents who completed the weekly IFA supplementation in schools N: # of adolescents who completed the 3-month IFA supplementation D: # of adolescents targeted	Program data	No baseline data yet.		
5	Family Planning; HIV & STI (R)	Percentage of adolescents with first sex before age 18 years N: # of adolescents with first sex before age 18 D: # of adolescents surveyed	YAFSS	15-19 yo: 25.7% (2013)		
6	Family Planning (P)	Modern contraceptive prevalence rate among adolescents N: # adolescents who use modern contraception methods to prevent pregnancy D: # of adolescents surveyed who engage in sex	NDHS	Female 15-19: 2.4% (2013)		
7	Family Planning (P)	Percentage of adolescents with unmet family planning needs N: # of currently married adolescent women with unmet family planning need D: # of adolescent married women surveyed	NDHS	Female 15-19 yo: 28.7%		

8	Safe Motherhood (S)	Percentage of adolescent pregnant mothers who had four (4) antenatal care visits N: # of adolescents who had 4 ANCs D: # of adolescents surveyed with live birth in the two years preceding the survey	NDHS	No data disaggregated for 15-19 yo in 2013 IHBSS		
9	Safe Motherhood (S)	Percentage of adolescents births delivered in health facility N: # of births delivered in health facility D: # of adolescents surveyed with live birth in the five years preceding the survey	NDHS	Female <20: 63.4%		
10	Safe Motherhood (S)	Percentage of adolescent births attended by skilled health care provider N: # of births delivered in health facility D: # of adolescents surveyed with live birth in the five years preceding the survey	NDHS	Female <20: 96.1		
11	Safe Motherhood (S)	Percentage of adolescents pregnant mothers who had postnatal care N: # of adolescent pregnant mothers who had postnatal care D: # of adolescents surveyed with live birth in the two years preceding the survey	NDHS	Female <20: 72.7%		
12	HIV & STI (P)	Percentage of condom use among last sex among adolescent key populations N: # of adolescents who used a condom during last sex D: # of adolescents key populations surveyed who engage in sex	IHBSS	MSM 15-19 yo: 34.82% FSW 15-19 yo: 64.58%, PWID M 15-19 yo: 18.9% PWID F 15-19 yo: 20% (2015)		
13	HIV & STI (P)	Percentage of adolescent people who inject drugs (PWID) who used clean injecting equipment N: # of adolescent PWIDS who use clean injecting equipment D: # of adolescent PWIDs surveyed	IHBSS	PWID M 15-19 yo: 55.01% PWID F 15-19 yo: 83.33% (2015)		
14	HIV & STI (S)	Percentage of adolescent key populations who had an HIV test and know their status N: # of adolescents who get tested for HIV D: # of adolescent key populations surveyed	IHBSS	MSM 15-19yo: 8.17% (2015) FSW 15-19yo: 11.2% (2014) PWID M 15-19yo: 11% (2015)		
15	HIV & STI (S)	Estimated number of adolescent people living with HIV (PLHIV) who are alive and on ART N: # of adolescent PLHIV who are alive and on ART D: # of estimated adolescent PLHIV	HARP, AEM/ Spectrum	Female 10-14yo: 5, Male 10-14yo: 1 (2016) Female 15-19yo: 17, Male 15-19yo: 457(2016)		

16	Oral Health (P)	Percentage of adolescents who brush their teeth two times a day N: # of adolescents who reported brushing their teeth atleast two times a day D: # of adolescents surveyed	School-based survey	No baseline data.		
17	Oral Health (S)	Percentage of adolescents who go to the dentist every three months N: # of adolescents who reported going to the dentist atleast every 3 months D: # of adolescents surveyed	School-based survey	No baseline data.		
18	Vaccine Preventable Diseases/ VPD (S)	Percentage of female adolescents 9-10 years with complete HPV vaccination	Program data	No age-disaggregated baseline data.		
19	Vaccine Preventable Diseases/ VPD (S)	Percentage of adolescents 12-13 years with complete MR/Td vaccination	Program data	No age-disaggregated baseline data.		
20	Mental health (R)	Percentage of adolescents who ever thought of committing suicide N: # of adolescents who reported ever thinking of committing suicide D: # of adolescents surveyed	YAFSS	15-19 yo: 7.3% (2013)		
21	Mental health (P)	Percentage of adolescents who tend to bounce back quickly after hard times N: # of adolescents who reported being able to bounce back quickly after hard times (6 or more in a scale of 1-10) D: # of adolescents surveyed	School-based survey	No baseline data.		
22	Mental health (P)	Percentage of adolescents who have a hard time making it through stressful events N: # of adolescents who reported being having a hard time making it through stressful events (6 or more in a scale of 1-10) D: # of adolescents surveyed	School-based survey	No baseline data.		
23	Mental health (S)	Percentage of adolescents accessing mental health services	Program data	No baseline data.		
24	Violence (S)	Percentage of adolescent cases managed by VAWC within 12 months a. Medical needs managed b. Psychological needs managed	VAWCRS	No baseline data.		
25	Injury (P)	Percentage of adolescents who wear a helmet when driving or riding a motorcycle N: # of adolescents who reported wearing a helmet every time they drive or ride a motorcycle D: # of adolescents surveyed who drive or ride a motorcycle	School-based survey	No baseline data.		
26	Injury (P)	Percentage of adolescents who wear a seatbelt when driving or riding a car N: # of adolescents who reported wearing a seatbelt every time they drive or ride a car D: # of adolescents surveyed who drive or ride a car	School-based survey	No baseline data.		

27	Injury (P)	Percentage of adolescents who know how to swim N: # of adolescents who reported knowing how to swim D: # of adolescents surveyed	School-based survey	No baseline data.		
28	Drugs (R)	Percentage of adolescents who refused someone who offered prohibited drugs	School-based survey	No baseline data.		
29	Drugs (R)	Percentage of adolescents who did not use prohibited drugs within school premises	School-based survey	No baseline data.		
30	Drugs (S)	Percentage of adolescent drug dependents who have completed the rehabilitation program N: # of adolescents who completed the drug rehabilitation program D: # of adolescents who are drug dependents	IDADIN (annually	No baseline data.		
31	Alcohol (P)	Percentage of adolescents who did not drink alcohol within school premises	School-based survey	No baseline data.		
32	Tobacco use (R)	Percentage of never smokers who are likely to initiate smoking next year		13-15 yo: 10.5% (2013)		
33	Tobacco use (R)	Percentage of adolescents who did not smoke within school premises	School-based survey	No baseline data.		

7.6 Data sources and flow of reporting

i. Philippine Heath Statistics (PHA)

The Philippine Health Statistics is the annual publication of the Department of Health Epidemiology Bureau that consolidates the country's statistics on vital events, including national data on Natality, Morbidity, and Mortality. It primarily serves to provide information that helps government officials in the health sector in the assessment, planning, implementation, and monitoring and evaluation of various health programs and services. For the AHDP Monitoring & Evaluation (M&E), data from the Philippine Health Statistics serves to provide information on morbidities and mortalities which are the impact level indicators.

ii. Young Adult Fertility & Sexuality Survey (YAFSS)

The Young Adult Fertility & Sexuality Survey is the country's primary source of information on sexual and non-sexual risk behaviors and its determinants, both at the national and regional levels. The survey has already been conducted by the Demographic Research and Development Foundation (DRDF) in partnership with the University of the Philippines Population Institute (UPPI) for four rounds, with the latest survey accomplished in 2013. The survey's objectives include: a) To track some core indicators of youth well-being, risk and non-risk behaviors and other outcomes and the determinants of such outcomes, and b) To provide estimates of current levels of the indicators for Adolescent Reproductive Health that are being tracked by DOH & UNFPA. Specifically for the AHDP M&E, this survey provides data on the adolescent population's, use of drugs & tobacco, nutrition, mental health, knowledge on HIV, and sexual practice which are outcome and impact level indicators.

iii. National Demographic Health Survey (NDHS)

The National Demographic Health Survey conducted by the Philippine Statistics Authority is part of the worldwide Demographic and Health Surveys (DHS) program curated to gather data to estimate current levels of fertility, mortality, and migration. Four rounds of survey has already been conducted, with the latest having been conducted in 2013. For the AHDP M&E, the survey serves to provide data regarding the adolescent populations' birth rate, and access to family planning and safe delivery services which are outcome and impact level indicators.

iv. Field Health Services Information System (FHSIS)

The Field Health Services Information System managed by the Department of Health Epidemiology Bureau is the premier information system of the country that provides data on health service delivery and program accomplishment indicators at the national, regional, provincial, district, municipal, and barangay levels. The FHSIS issues a comprehensive report annually, with the latest report containing data from 2015. For the AHDP M&E, the FHSIS data serves to provide information regarding the number of teenage pregnancy cases in the Philippines as well as other program data.

v. National Nutrition Survey (NNS)

The National Nutrition Survey conducted by the Food and Nutrition Research Institute of the Department of Science and Technology (FNRI-DOST) every 5 years serves as the key source of data for the national government for nutrition-related information and other health matters. The survey aims to determine and evaluate the food intake, nutrition and health status of Filipinos, and provide official statistics on food, nutrition and health situations in the country. For the AHDP M&E, the NNS data serves to provide most information at the impact and outcome level for the nutrition-related indicators.

vi. Integrated HIV Behavioral and Serologic Surveillance (IHBSS)

The Integrated HIV Behavioral and Serological Surveillance of the Department of Health Epidemiology Bureau is the country's national active surveillance system among key populations, which is conducted every 2 to 3 years. The IHBSS aims to: a.) determine the prevalence of HIV and Syphilis among the key populations and establish trend over time, b.) determine behavioral factors associated with STI and HIV transmission and its effect on the HIV epidemic in the country, c.) determine the outcome of STI and HIV intervention programs, and d.) provide strategic information to guide STI and HIV policies, programs and services. For the AHDP M&E, the IHBSS data serves to provide information on the prevalence of HIV, Hepatitis B, and Syphilis, knowledge on HIV, and preventive behaviors against HIV & STIs.

vii. HIV, AIDS, and ART Registry of the Philippines (HARP)

The HIV, AIDS, and ART Registry of the Philippines is the national surveillance system for HIV & AIDS managed by the Department of Health Epidemiology Bureau. The HARP includes the HIV continuum of care cascade from HIV diagnosis, to linkage to care, to ART enrolment, to viral load suppression and to death. Strategic information from the HARP database is released through a monthly report of aggregate data. For the AHDP M&E, the HARP will provide data on the newly diagnosed cases and AIDS-related mortality among adolescents, and the number of adolescents living with HIV who are alive and on ART.

viii. Global Youth Tobacco Survey (GYTS)

The Global Youth Tobacco Survey is a school-based, tobacco-specific survey of the World Health Organization (WHO) and U.S. Centers for Diseases Control and Prevention (CDC) in partnership with the Department of Health Epidemiology Bureau together data about the smoking practices among youth in the Philippines. It is a nationwide survey conducted every 4 years, with the latest survey having been conducted in 2015. Its objectives are as follows: a.) To document and monitor prevalence of tobacco use including: cigarette smoking, and current use of smokeless tobacco, cigars or pipes, and b.) To better understand and assess students' attitudes, knowledge and behaviors related to tobacco use and its health impact, including cessation, environmental tobacco smoke, media and advertising, minors' access, and school curriculum. For the AHDP M&E, the GYTS serves to provide data on the prevalence of smoking among the youth, and the adolescents' knowledge and practices on smoking.

ix. Nat'l Baseline Study on Violence Against Children (NBS-VAC)

The National Baseline Study on Violence Against Children is a baseline study conducted by the Council for the Welfare of Children (CWC) and supported by United Nations Children's Fund (UNICEF) in 2015 in the Philippines to gather data on the incidence and various forms of violence committed against the Filipino youth. The objectives of the survey are as follows: a.) To estimate the national prevalence of violence against children and various forms and settings, b.) To enumerate the social and health consequences of violence against children, c.) To assess the children's awareness and utilization of health, legal and welfare services related to violence against children, d.) To obtain stakeholdres' views about violence against children including perceived reasons why it persists. For the AHDP M&E, the NBS-VAC serves to provide data regarding the cases of violence among the adolescents in the country.

x. School-based survey

The Global Health School-based Survey (GSHS) is a surveillance project spearheaded by the World Health Organization designed to gather data on the behavioural risk factors and protective factors among the youth. The survey is conducted every 4 years, with the latest round having been conducted in 2015. For the AHDP M&E, data gathered by the GSHS will provide information on the risky behaviours engaged by the adolescents, their knowledge on various components of health such as nutrition, family planning, HIV, smoking, alcohol, and drugs, their oral health practices, as well as their injury-preventive practices.

In addition to the GSHS, the DOH-Epidemiology Bureau (DOH-EB) will also conduct a school-based survey in 2018 focusing on adolescent health indicators. This survey will take into account the data needs in this M&E plan and will potentially be a rich source of adolescent health data.

a. Flow of reporting
For impact indicators. The impact indicators are heavily dependent on national surveys conducted by DOH or other agencies, and case and death reports from surveillance systems. DOH-EB will review available reports every year to update the **Annual Regional Scorecards B** if new information is available. DOH-EB will provide the accomplished scorecard to the AHDP National Program Manager who will cascade it to the Regional Program Coordinators.

For outcome indicators. The outcome indicators are also reliant on national surveys which are conducted only 2 to 5 years. DOH-EB will review available reports every year to update the information on the Knowledge and Behavioral Indicators and will share this with the AHDP National Program Manager who will cascade it to the Regional Program Coordinators.

Data on impact and outcome indicators will be discussed with other DOH component programs through the internal AHDP Technical Working Group (TWG), before they are cascaded to the regional offices.

DOH-EB	**AHDP National Office (DOH)**	**AHDP Regional Office (DOH)**
• Review available reports annually • Update information on impact and outcome indicators, including Annual Regional Scorecard B.	• Review report shared by DOH-EB. • Discuss data with other DOH component programs (internal TWG) • Cascade report to Regional Program Coordinators	• Review shared by AHDP Program Manager • Discuss data with other DOH regional component programs • Utilize strategic information to monitor and plan for programs.

For AHDP output indicators.

The AHDP Regional Program Coordinator will submit the accomplished *Regional AHDP Monitoring Tool* biannually to the AHDP National Program Manager. AHDP will then review and file all the reports. The AHDP Program Manager will share reports with DOH-EB biannually. DOH-EB will consolidate the information as *Annual Regional Scorecards A* and will provide feedback to the AHDP Program Manager who will then cascade the information to the Regional Program Coordinators.

Annexes, Resources, and References

Annex A.

National Policy and Strategic Framework on Adolescent Health and Development

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

MAR 2 1 2013

ADMINISTRATIVE ORDER
No. 2013 - 0013

SUBJECT: <u>National Policy and Strategic Framework on Adolescent Health and Development</u>

I. BACKGROUND AND RATIONALE

The twenty million (19,844,578) adolescents age 10-19 years comprise 21.5% of the country's population (NSO, 2010). Thus, they are essential to achieve the Millennium Development Goals and should be part of the national strategy to reduce poverty.

Adolescents face many threats to their health and well-being. While mortality rate in this age group are low, they are susceptible to conditions that are related to their increased mobility, socialization (Valenzuela-Teoxon, 2007), and risk-taking behavior. One in every 10 young women ages 15-19 is already a mother, doubling the likelihood of maternal death compared to those over 20 years (DOH, UNFPA, WHO, 2002) and increasing the risk of dropping out of school and facing limited economic opportunities. Sixteen (16) percent of abortion attempts occur among teenagers (Singh, 2006). Sexually Transmitted Infections, HIV and AIDS, drugs, alcohol, and smoking are also on the rise among adolescents. Drowning and transport accidents are among the top five causes of death among the 10-14 and 15-19 age group (DOH, 2005). Three percent of young people ages 15-27 have attempted to commit suicide (UPPI/DRDF, 2002). Issues of assault and bullying are also causing increasing concern among parents, educators, and adolescents themselves.

Administrative Order 34-A, s 2000, the Adolescent and Youth Health (AYH) Policy was issued in April 2000, creating the Adolescent and Youth Health Sub-program under the Program for Children's Health Cluster of Family Health. It envisions "well-informed, empowered, responsible and health adolescents & youth" and had a mission to "ensure that all adolescents & youth have access to quality comprehensive health care and services in an adolescent & youth-friendly environment".

In 2006, the Department of Health (DOH) created the Technical Committee for Adolescent and Youth Health Program (AYHP), composed of both government and non-government organizations dedicated to uplifting the welfare of adolescents and tasked to revitalize the AYHP. The committee embarked on a Strategic Plan for Accelerated Action on Adolescent Health. In 2010, the National Center for Disease Prevention and Control (NCDPC) drafted a National Standards and Implementing Guide for Adolescent Friendly Health Facility, an Adolescent Job Aid manual and a Primer on Legal Bases for the Adolescent Health Services in the Philippines.

Due to an increasing health risky behavior among our Filipino adolescents, the DOH embark on revising the current policy and address the major adolescent health problems, marginalized groups and humanitarian emergency settings and to provide

clear understanding among implementers and to guarantee program sustainability thus this Order is developed.

II. **DECLARATION OF POLICIES**

1. *The 1987 Philippine Constitution* charges the State to promote and protect the youth's physical, moral, spiritual, intellectual, and social well-being and prioritizes the health of children.

2. *The Convention on the Rights of the Child,* which the Philippines ratified with the force of law in 1990, defines a child as "every human being below the age of 18 years unless, under the law applicable, majority is attained earlier" and directs States to "strive to ensure that no child is deprived of his or her right of access to such health care services."The Committee on the Rights of the Child, in its General Comment No. 4 (2003) emphasized Adolescent Health and Development in the context of the CRC (CRC/GC/2003/4)

3. The Report of the International Conference on Population and Development(ICPD, 1994), Chapter VI, B. 6.15, states that "Youth should be actively involved in the planning, implementation and evaluation of development *activities that have a direct impact on their daily lives. This is especially important* with respect to information, education and communication activities and services concerning reproductive and sexual health, including the prevention of early pregnancies, sex education and the prevention of HIV and other sexually transmitted diseases."

4. In September 2000, the Philippines and other member nations ratified and signed the Millennium Declaration which embodies global and country commitments, specific targets and milestones for 2015, including the Eradication of extreme poverty and hunger (MDG 1), Promotion of gender equality and empowerment of women (MDG 3), Reduction of Child Mortality (MDG 4), Improvement of Maternal Health (MDG 5), and Combating HIV and AIDS, malaria, and other diseases (MDG 6)

5. Republic Act No. 10354, signed into law on December 21, 2012, provided for a National Policy on Responsible Parenthood and Reproductive Health.

6. Administrative Order No. 43 s. 2000 adopted the elements of Reproductive Health Framework which includes services for Adolescent and Youth Health (AYH), Violence Against Women & Children (VAWC), Family Planning (FP), Maternal and Child Health & Nutrition (MNCHN), Prevention and Management of Abortion and its Complication (PMAC), Prevention and Management of Reproductive Tract Infections (RTI), Education and Counseling on Sexuality and Sexual Health, Breast & Reproductive Tract Cancers & other Gynecological Conditions, Men's Reproductive Health, and Prevention & Management of Infertility & Sexual Dysfunction.

7. AO 2008-0029 was enacted for Implementing Health Reforms for Rapid Reduction of Maternal and Neonatal Mortality

8. AO 2006-0016 provided a National Policy and Strategic Framework on Child Injury Prevention

9. AO 2007-0010 provided a National Policy on Violence and Injury Prevention

10. AO 2011-0003 enacted the National Policy on Strengthening the Prevention and Control of Chronic Lifestyle Related Non-Communicable Diseases

11. RA 8371 promotes the Rights of Indigenous Cultural Communities/ Indigenous Peoples

III. OBJECTIVES

This Order aims to:

1. Provide a strategic framework for the Adolescent Health Program that is anchored on Universal Health Care
2. Provide policy direction and guidance for DOH offices, its attached agencies, LGUs, and development partners in prioritizing interventions for adolescent health

IV. COVERAGE AND SCOPE OF APPLICATION

This Order shall apply to the entire public and private health system, to include DOH bureaus, Centers for Health Development (CHDs), hospitals and other health facilities, attached agencies, local government facilities, external development partners and other stakeholders implementing health programs for and with adolescents.

V. DEFINITION OF TERMS

1. Adolescent: refers to young people between the ages of 10 and 19 years who are in transition from childhood to adulthood (RA10354) and are the primary targets of this Order, differentiated from "youth" and "young people".

2. Early adolescence is from 10-13 years old. Middle adolescence 14-16 years. Late adolescence 17-19 years. (Philippine Pediatric Society)

3. Children refers to person below eighteen (18) years of age or those over but are unable to fully take care of themselves or protect themselves from abuse, neglect, cruelty, exploitation or discrimination because of a physical or mental disability or condition.(RA 7610).

4. Adolescent Health is a state of complete physical, mental and social well-being of persons aged 10-19 years.

5. Reproductive Health Rights of Adolescents and Youth refer to their human right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health (CPD, 2012)

6. Early pregnancy: refers to pregnancy in women less than 20 years old.
7. Bullying or Peer Abuse: refers to willful aggressive behavior that is directed towards a particular victim who may be out-numbered, younger, weak, with disability, less confident, or otherwise vulnerable (DepEd)

8. Empowerment: refers to having a sense of self-worth; to have and to determine choices, access to opportunities and resources, the power to control their own lives; and the ability to influence the direction of social change to create a more just social and economic order, nationally and internationally.(UN, 2001)

9. Adolescent Participation: refers to public processes in which adolescents are involved in decision making, either directly or through representatives. Adolescent

participation recognizes adolescents as citizens and stakeholders in the present – not just in the future. (IAWGCP, 2007)

10. Evolving Capacities: The UNCRC recognizes that children in different environments and cultures, with different life experiences, will acquire competencies at different ages, and this process will vary according to circumstances. Children do not acquire competencies merely as a consequence of age, but rather through experience, culture, and levels of parental support and expectation. Evolving capacities is central to the balance between empowerment and protection. (Save the Children, 2007)

11. Life skills are abilities for adaptive and positive behavior that enable individuals to deal effectively with the demands and challenges of everyday life (WHO definition)

12. The Private Sector refers to health providers and facilities (individual practitioner, clinics, hospitals, facilities, drug outlets) licensed and regulated under existing laws but otherwise operating outside the ownership or management of the government.(DOH AO 2012-0004).

VI. GENERAL GUIDELINES
1. The Adolescent Health and Development Program (AHDP) shall be in accordance with the thrusts of the National Objectives for Health, the Philippine Development Plan, the AIDS Medium Term Plan, the Millennium Development Goals, and the Philippine Youth Development Plan of the National Youth Commission.

2. The AHDP shall target primarily adolescents age 10-19 years. This will complement the roles of the Council for the Welfare of Children, which serves to protect the rights of children under 18 years old, and the National Youth Commission, which is mandated to provide leadership in the formulation of policies for youth ages 15-30. Few programs address the unique health needs of very young adolescents ages 10-14. Thus resources need to be directed to this age group while also preventing pregnancies before the age of 20, when there is an increased risk of maternal (DOH, UNFPA, WHO, 2002) and infant (Phipps, 2002) mortality, low birth weight babies (NSO) , and limiting of the woman's education and livelihood opportunities.

3. The AHDP shall aim to achieve the following health outcomes: (1) Healthy Development; (2) Healthy Nutrition; (3) Sexual and Reproductive Health; (4) reduction of substance use; (5) reduction of injuries and mortality, morbidity and psychosocial consequences of injures; (6) reduction of all forms of violence and mortality, morbidity and psychosocial consequences of violence; and (7) Mental health. (National Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services, DOH, 2010)

4.4. The AHDP recognizes the risks inherent to early sexual initiation or having one's first sexual intercourse occurring before the adolescent is physically and psychosocially capable of dealing with the consequences of sexual intercourse and shall aim to delay sexual initiation among adolescents.5. The AHDP shall respect the rights of all adolescents. Specific strategies for marginalized and vulnerable

groups need to be put in place to promote equity and inclusion. Marginalized groups include, but are not limited to, the following: Adolescents in Indigenous Communities as defined in RA 8371, Adolescents (Persons) with Disability (RA 9442), Adolescents (Children) in Conflict with the Law (RA 9344), Drug-dependent Adolescents (RA 9165), Abandoned and Neglected Adolescents (RA 9523), Adolescents on the Streets, Adolescents in Commercial Sexual Exploitation, Adolescent Survivors of Calamity, Adolescents in Situations of Armed Conflict, Adolescent Key Affected Populations, Adolescent Survivors of Abuse and Exploitation (RA 7610).

6.6. Program strategies shall include:

a. Health Promotion and Behavior Change for adolescents to utilize health services, practice healthy behaviors, avoid risks, and participate in governance and policy decisions affecting their health and development

b. Improving access to quality and adolescent-friendly health care services and information for adolescents, including access to quality hospitals and health care facilities following the National Standards and Implementation Guide for Adolescent-friendly Health Services and utilizing various settings outside the health system, such as schools, cruising sites, and social media, to promote adolescent health.

c. Expanding Health Insurance. The DOH shall design a proposal for an Adolescent Health Package with PhilHealth while mobilizing other sources of financing such as local government and the private sector.

d. Enhancing skills of service providers, families, and adolescents to protect their health and development

e. Strengthening partnerships among adolescent groups, government agencies, civil society, the private sector, families and communities to make them accountable for the achievement of MDGs

f. Strengthening policy at all levels to ensure that all adolescents have access to information and services

g. Ensuring sufficient resources to implement a sustainable adolescent health program

h. Resource mobilization. The Department of Health and Centers for Health Development shall provide funds for technical assistance, monitoring, and advocacy. The Council for the Welfare of Children, National Youth Commission, Department of Education, and Department of Social Welfare and Development shall provide counterpart funds to implement the Adolescent Health and Development Program within the scope of their responsibility. The Philippine Health Insurance Corporation shall develop benefits coverage for adolescent members and beneficiaries. Local government units shall provide funding for the implementation of the AHDP in their area, mobilizing external resources and internal funding such as SK funds and the GAD budget.

7. Monitoring and Evaluation systems shall be strengthened to improve access to strategic information to effectively assess the attainment of goals and utilize data in developing programs to forward adolescent health. To this end, the DOH shall develop a Five-year Strategic Plan for the AHDP with Goals, Objectives, Indicators, and Targets, including a monitoring and evaluation plan to measure attainment of

the goals and objectives. The DOH and the National Statistics Office shall provide the necessary data, including baseline data disaggregated for the 10-19 age groups.

VII. STRATEGIC FRAMEWORK

Strategies of the AHDP shall be designed in accordance with the Program's Vision, Mission, and Goals. Health status outcomes and adolescents' rights shall be enjoyed through positive behavior change, which are achieved by a variety of strategies. In turn, these strategies will be built upon actionable program components. These elements are non-linear as multiple health and development goals call for a range of interventions delivered in an integrated manner.

1. **VISION AND MISSION**

   Vision: Well-informed, empowered, responsible and healthy adolescents who are leaders in society

   Mission: Ensure that all adolescents have access to quality comprehensive health care and services in an adolescent-friendly environment

2. The AHDP's **OVERALL GOALS** are to improve the health status of adolescents and to enable them to fully enjoy their right to health.

3. **GUIDING PRINCIPLES**

   a. The Adolescent Health Program is guided by the Convention on the Rights of Children which states that it should be of the *Best interests of the child; the adolescent's rights are indivisible and interrelated; Non-discrimination, have Access to accurate information; have access to life-saving interventions* as long as he/she is mature enough to face the consequences; *contain a meaningful adolescent participation; recognize adolescent as a whole person needing supportive environment; suitable Life skills to help him/her cope with and manage their lives in a healthy and productive manner; capacitate the family as the primary source of basic knowledge, behavior, attitudes, and skills necessary for his/her well being; a Life Cycle Approach where it continue to affect health and development of an adolescent from infancy to parenthood;* Respect the adolescent's right to *privacy and confidentiality,* including with respect to advice and counseling on health matters; Recognize the involvement, commitment, accountability, and *responsibility in all areas of* sexual and reproductive health as well as the protection and promotion of reproductive health concerns specific to men and boys(UNFPA); Recognize the positive impact of *peer education,* and the positive influence of *proper role models,* especially those in the worlds of arts, entertainment and sports (CRC/GC/2003/4)

STRATEGIC FRAMEWORK

Well-informed, empowered, responsible and healthy adolescents who are leaders in society	Vision
Improved Health Status / Adolescents able to enjoy their right to health	Overall Goals
Increased Service Utilization / Adoption of Healthy Behaviors / Avoidance of Risky Behaviors / Participation in Community Development	Behavioral Objectives
Access to quality services / Health insurance for adolescents / Skilled service providers, families and adolescents / New and stronger partnerships / Information management / Policy support	Strategies
Adolescent-Friendly Health Services / Financing / Capacity Building / Monitoring & Evaluation / Research / Partnership Building / Advocacy	Program Components

VIII. IMPLEMENTING MECHANISMS

1. ORGANIZATIONAL STRUCTURE

The DOH shall act as the lead agency, along with the LGUs, for the implementation of this Order. The National Center for Disease Prevention and Control - Family Health Office shall designate a Sub-program Manager for Adolescent Health and Development. The DOH shall convene a Technical Working Group on Adolescent Health and Development whose primary role is to oversee the implementation of the Program and monitor progress based on the M&E Framework.

IX. ROLES AND RESPONSIBILITIES

1. **DOH - National Center for Disease Prevention and Control (NCDPC), National Center for Health Promotion(NCHP), National Epidemiology Center (NEC), Philippine National Aids Council (PNAC)**
   - Serve as the focal point for overall planning, management, monitoring, and evaluation of the AHDP
   - Provide technical leadership in all matters pertaining to the AHD
   - Advocate for adolescent health and development in national and local public forums
   - Ensure meaningful participation of adolescents at all stages of the program cycle

- Create, strengthen, and maintain inter-agency links and public-private partnerships
- Formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum in coordination with the DSWD, DepEd, CHED, and TESDA,
- Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children
- Development, implementation, and monitoring of a Health Promotion, Communications, and Advocacy Plan for Adolescent Health and Development
- Provide age-disaggregated data necessary to for monitoring and evaluation of results of the AHDP
- Provide technical assistance and guideline in matters pertaining to STI and HIV and AIDS and services for Young Key Affected Populations

2. **Center for Health Development**
   The Centers for Health Development are responsible for:
   - Localization and dissemination of this Order
   - Providing technical assistance to local government units in implementation
   - Monitoring results and reporting these to the DOH Central Office
   - Creating inter-agency links to support local government units in implementation of the AHDP
   - Advocating for policies and resources at the local level.
   - Ensuring that hospitals and health care facilities under CHD management meet the National Standards for the Provision of Adolescent-Friendly Health Services.

3. **Department of Education (DepEd), Commission on Higher Education (CHED), and Technical Education and Skills Development Authority (TESDA)**
   - With the DOH and DSWD, formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum
   - Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children
   - Integrate other adolescent health concerns in school curriculum
   - Mobilize teachers, guidance counselors, and parents to implement the AHDP

4. **Department of Social Welfare and Development (DSWD)Commission on Population (POPCOM),National Anti-Poverty Commission (NAPC),**
   - With the DOH, DepEd, CHED, and TESDA, formulate an age- and development-appropriate Reproductive Health and Sexuality Education curriculum
   - Provide parents with adequate and relevant scientific materials on the age-appropriate topics and manner of teaching Reproductive Health and Sexuality Education to their children

- Provide adolescent-friendly health services and protection to adolescents who are out of school, with disabilities, in conflict with the law, drug dependent, on the streets, in prostitution, survivors of calamity, in situations of armed conflict, and survivors of abuse and exploitation
- Train multi-disciplinary teams for Women and Child Protection Units and sustain 24/7 Crisis Interventions Units in every region
- Formulate policies, programs and measures on adolescent participation
- Assist in monitoring and evaluation of results of the AHDP
- Create inter-agency links to build the support of local government units for the implementation of the AHDP
- Advocate, mobilize and generate resources for adolescent development

5. **Council for the Welfare of Children (CWC)**
   - Integrate adolescent health and development in national and local development plans
   - Advocate for adolescent rights as enshrined in the CRC
   - Include adolescent health and development issues in the Country Report to the CRC

6. **Commission on Human Rights (CHR)**
   - Integrate the rights of adolescents in information and public advocacy, research, and training
   - Investigate violations of adolescents' rights and provide legal aid

7. **National Statistics Office (NSO)**
   - Provide age-disaggregated data necessary to for monitoring and evaluation of results of the AHDP

8. **Philippine Health Insurance Corporation (PhilHealth)**
   - Provide benefits coverage for adolescents, particularly marginalized sub-sectors

9. **Professional Medical and Allied Medical Associations, Academic Institutions, Adolescent and Youth Organizations**

   - Develop members' capacity to provide adolescent-friendly health services
   - Provide technical assistance in the formulation of policies, guidelines, and tools for adolescent health and development
   - Contribute to research on adolescent health and development
   - Participate in monitoring and evaluation of results of the AHDP
   - Advocate for adolescent rights as enshrined in the CRC
   - Participate in the design and implementation of adolescent health and development programs
   - Participate in the monitoring and evaluation of results of the AHDP

10. **Non-Government, Faith-based, Civil Society Organizations, the United Nations and other development partners working with and for adolescents**
   - Implement adolescent-centered programs and outreach services in priority communities that are consistent with the AHDP in coordination with government agencies
   - Provide technical assistance in the formulation of policies, guidelines, and tools for adolescent health and development
   - Contribute to research on adolescent health and development
   - Advocate, mobilize and generate resources for adolescent health and development

11. **Private Sector**
   - Enforce policies for the protection of adolescent employees
   - Implement workplace programs for parents of adolescents
   - Support adolescent health and development activities in communities, schools, and other settings

12. **Local Government Units**
   - The provision of reproductive health information, care and supplies shall be the joint responsibility of the National Government and Local Government Units (LGUs).
   - LGUs must ensure provision of basic adolescent health care services including, but not limited to, the operation and maintenance of facilities and equipment necessary for the delivery of a full range of reproductive health care services and the purchase and distribution of family planning goods and supplies as part of the essential information and service delivery package defined by DOH.
   - LGUs, specifically the Rural Health Units, City Health Offices, and Provincial Health Offices, are responsible for designing, funding, implementing, and monitoring local Adolescent Health and Development programs suited for adolescents in their area, in partnership with youth, government agencies, civil society, and the private sector, under the technical guidance of the CHD and this Order. LGUs should design specific strategies to reach marginalized and vulnerable adolescent sub-sectors. They should ensure meaningful participation of adolescents and communities in this process. Hospitals and health care facilities under LGU management must meet the National Standards for the Provision of Adolescent-Friendly Health Services.

X.   REPEALING CLAUSE

The provisions of previous Orders and other related issuances inconsistent or contrary with the provisions of this Administrative Order, including AO 34-A s, 2000, are hereby revised, modified, repealed or rescinded accordingly. All other provisions of existing issuances which are not affected by this Order shall remain valid and in effect.

XI. SEPARABILITY CLAUSE

If any provision of this Order is declared unauthorized or rendered invalid by any court of law or competent authority, those provisions not affected thereby shall remain valid and effective.

XII. EFFECTIVITY

This Order shall take effect immediately.

ENRIQUE T. ONA, MD
Secretary of Health

Annex B.

Case Studies: Best Practices

Connecting to young people by speaking their language

Even in remote areas, mobile technology proves to be the easiest and least expensive way to communicate and advocate. It also allows for immediate response, which proved successful in the experience of Ifugao's ARH Text Tanong program.

Under the UNFPA 6th Country Program, teen centres were established in collaboration with the Sangguniang Kabataan and the provincial government. On the invitation of schools, organizations or municipal governments, the

Provincial Population Office (PPO) in coordination and collaboration with the Provincial Health Office, conducts a one-day ARH session among different youth groups – both in and out-of-school – covering topics such as drug abuse, life skills, delaying sexual engagement, sexually transmitted infections, including HIV and AIDS, and alcoholism. During a post assessment of ARH session facilitators, a problem gave rise to an opportunity. It had become apparent that the youth participants were not as engaged during the open forum. They felt inhibited asking questions in front of peers or classmates, especially if these pertained to personal matters.

Thus was born the ARH Text Tanong Program. Participants were asked to text personal questions in the hope they would open up in the blanket of anonymity and privacy offered by their mobile phones. This would then allow support personnel to correct misconceptions about reproductive health issues and give advice on what to do, ultimately empowering the young texters. The ARH Text Tanong Program receives an average 20 text messages monthly, excluding the follow-up texts and exchanges. Majority of text messages have to do with teenage pregnancy, possible abortion, premarital sex, boy-girl relationship issues, parent-children relationships, STI/HIV/AIDS, use of condom, menstruation, and other health and lifestyle-related issues and concerns. The program's appeal to young people is easy to see. It is cost effective, most young people have mobile phones, it can generate quick response, and, best of all, it provides anonymous interactions, allowing conversations to be private and confidential.

Youth: Bedrock of Humanitarian Response I Typhoon Washi, Typhoon Bopha, Typhoon Haiyan

UNFPA has long supported youth networks in Asia-Pacific and around the world - enabling young people to become involved in local planning and decision-making and promoting health and human rights in communities. During emergencies, youth networks have played a vital role in humanitarian efforts, by identifying and working with vulnerable communities to ensure they are included in the response. Youth Peer Education Network and the Family Planning Organization of the Philippines supported in Cagayan de Oro, Philippines on December 2011 shortly after Tropical Storm Washi (Sendong) struck. Y-PEER and FPOP have already been working on peer education, and were instrumental in coordinating and training local youth volunteers during the response. UNFPA together with Y-PEER and FPOP quickly mobilized youth volunteers in various evacuation centres to help identify pregnant women in need of assistance and to organize information sessions for young people. When a crisis strikes, family and social structures are disrupted: adolescents may be separated from their families or communities, while formal and informal educational programmes are discontinued. Young people worked relentlessly at mobilizing youth who assisted in medical missions and helped distribute dignity kits. These kits included basic hygienic items such as soap, underwear and sanitary napkins. The opportunity to volunteer gave young people the chance to contribute and become productive amidst disaster, instead of becoming or feeling victims and fall into depression. Y-PEER and FPOP are convinced that this is a sustainable model, since young people are adaptable. The peer educators from the Sendong response became staff for the response to Super-Typhoon Bopha (Pablo) and Haiyan (Yolanda), working on the frontlines of those massive disasters. In this model, through this approach, we can really trust young people since they understand, they know, they become involved. They've seen how to do it. Whenever there is a disaster now, UNFPA together with Y-PEER and FPOP train and maximize the potentials of the young people, even the victims themselves, as part of the response. This gives the young victim feel a sense of usefulness and satisfaction rather than a feeling hopelessness and helplessness.

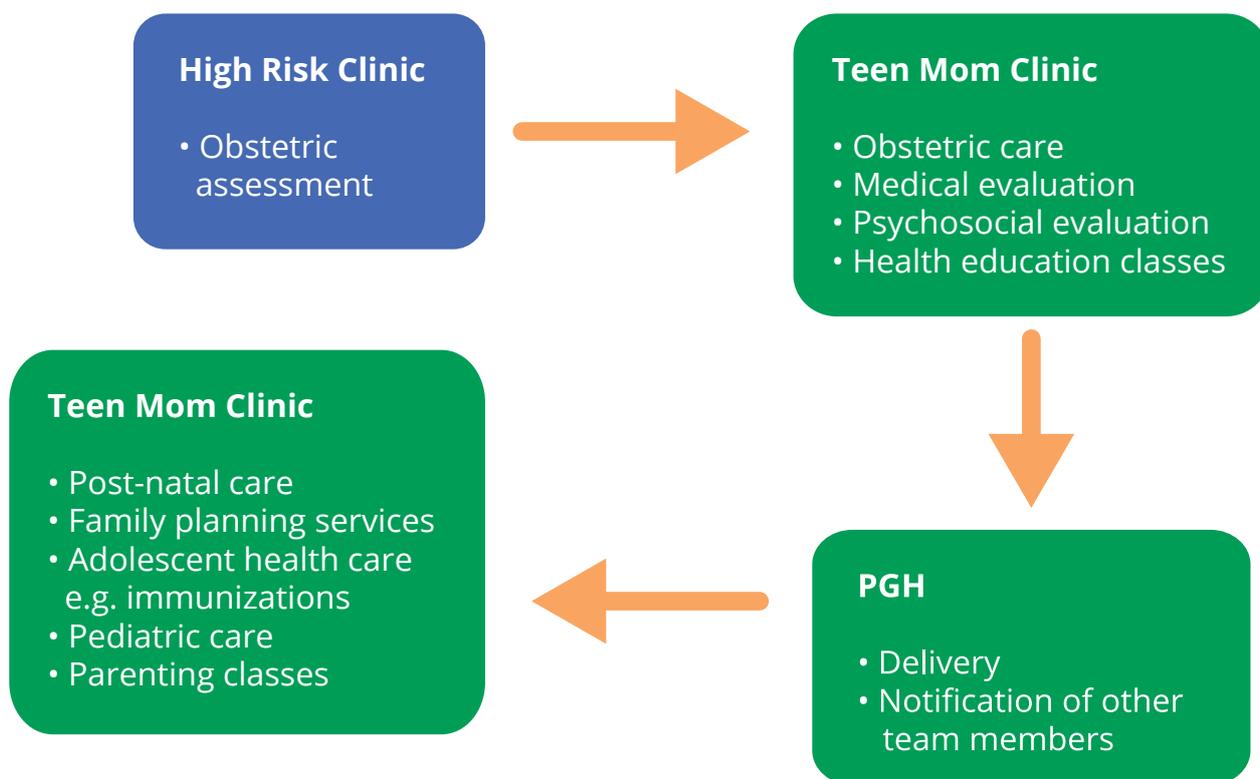## Partnership-defined Quality for Youth (PDQ-Y)

In Parañaque, Las Piñas, Taguig, South Cotabato and other sites, Save the Children introduced PDQ-Y as a method for improving the quality and accessibility of services whereby young people are involved in defining, implementing, and monitoring the quality improvement process. The PDQ-Y process involves youth, health care providers, and other stakeholders working together to overcome the inadequacies of health services for youth. Meetings are held separately with youth, community members and health workers to explore their ideas in an open and safe environment. Each group has separately defined characteristics and issues of quality health care. Then, health workers, community and youth come together to hear each other's ideas. Through discussion they begin to work as a team to develop a shared vision of quality. Together they identify and prioritize problems and constraints that make it difficult to achieve quality health services. They identify the barriers which prevent youth from obtaining adequate health care. Participants of this meeting also establish a Quality Improvement Team comprised of youth representatives and health workers. This team will continue to work on the issues identified.w

Philippine General Hospital's Teens and Tots Clinic

The PGH Teen Mom Program brings together a network of existing services, from Paediatrics and Adolescent Medicine, Obstetrics and Perinatology, Medical Social Services, Child Protection, Psychiatry, and Nutrition. They provide Medical (Obstetrical care/Adolescent health care, Nutrition counselling, Paediatric care), Psychosocial (counselling, social services, adoption services, Child Protection Unit), continued schooling (high school, TESDA), and Patient Education and Self-Management.

Process for Patients (PGH-Teen Moms Model)

High Risk Clinic

• Obstetric assessment

→

Teen Mom Clinic

• Obstetric care
• Medical evaluation
• Psychosocial evaluation
• Health education classes

↓

Teen Mom Clinic

• Post-natal care
• Family planning services
• Adolescent health care e.g. immunizations
• Pediatric care
• Parenting classes

←

PGH

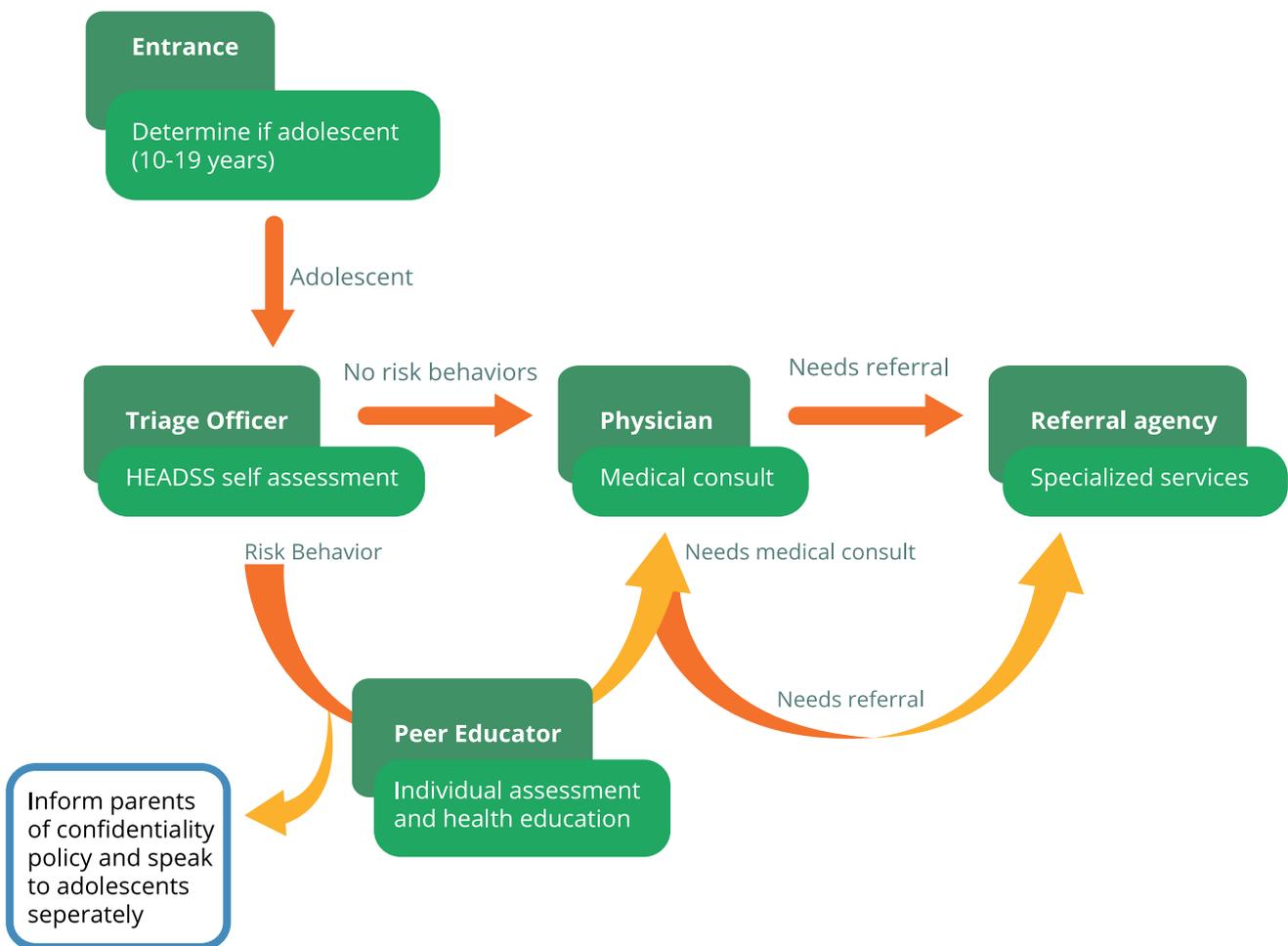• Delivery
• Notification of other team members

Partnering with the Private Sector: Visiting Health Professional Program (VHPP)

To address the risk of unplanned and/or unwanted pregnancies, the Community MNCHN (Maternal, Neonatal, Child Health and Nutrition) Scale Up Project or CMSU, a USAID cooperative agreement with the Integrated Midwives Association of the Philippines, developed the Visiting Health Practitioner Program (VHPP). In partnership with the Provincial Health Office of Cavite and the Department of Education, the program trained private midwives to facilitate lecture/discussion on Adolescent and Youth Reproductive Health inside the classroom of high schools in Cavite. The VHPP lecture series is composed of five (5) modules. Each module takes about 45 minutes to complete and is given during MAPEH through innovative learning methods such as games, role playing, visual/performing arts and interactive discussions

Inter-Agency Service Delivery Network (Parañaque model)

As Parañaque City was developing its service delivery network (SDN) for Maternal, Newborn, and Child Health and Nutrition, it acted on the opportunity to integrate services for adolescents in MNCHN SDP. The network includes the City Health Office, City Social Welfare and Development Office (CSWDO), the Department of Education (specifically for the Alternative Learning System (ALS)), the Police Department and private midwives. Aside from referrals the SDN conducts case inter-agency case conferences to discuss problems encountered. Cases discussed have included sexually transmitted infections, sexual abuse, teen pregnancy, and bullying.

Entrance

Determine if adolescent (10-19 years)

Adolescent

Triage Officer

HEADSS self assessment

No risk behaviors

Physician

Medical consult

Needs referral

Referral agency

Specialized services

Risk Behavior

Needs medical consult

Needs referral

Peer Educator

Individual assessment and health education

Inform parents of confidentiality policy and speak to adolescents seperately

Strengthening Partnerships in Iloilo for Adolescent-friendly health services

In order to deliver services for adolescents in a challenging legislative and social environment, the Iloilo model showcases a partnership between the local Health Office and the civil society organization (CSO) partner, the Family Planning Organization of the Philippines (FPOP). This allows young people to receive necessary treatment while simultaneously building capacity of the government in adolescent-friendly health services:

Government's Role
While government facilities are prohibited to provide family planning(FP) services to minors without parent's consent, there are several key areas that the local health office can be responsible for, including the procurement of commodities, provision of STI and HIV testing kits and treatment, and multi-sector coordination through local private service delivery networks and referral pathways.

CSO's Role
FPOP is responsible for the clinical operations that directly provide ASRH and HIV services to adolescents. Working closely with the local government, they are responsible for: outreach to young people (especially those most-at-risk); HIV counselling and referral for testing in DOH-accredited testing facilities); maternal health counselling and services (including PMTCT) for pregnant adolescents; and distribution of commodities (which are procured by the local health office). Local youth organizations are also mobilized for demand-generation for the available health services.

Mechanics
Health practitioners and trained youth partners assess and provide counselling and facilitate signing of consent forms for adolescents; Minors are given the option to involve or not involve their parents/guardian. If the minor refuses, dual consent will be facilitated: (i) the minor and (ii) the service provider/social worker. Services are delivered through medical missions targeting ages 10-24 and all medical practitioners are trained to use discussion tools and life skills curriculum on Adolescent Sexual and Reproductive Health (ASRH).

Annex C

Overview of Health Education Materials

i. Family Development Sessions (FDS)

DSWD conducts FDS for beneficiaries of the Pantawid Pamilyang Pilipino Program. The manual's objectives and content follows.

Layunin at Nilalaman ng Manual

Ang FDS Manual ay nagsisilbing gabay ng mga City/Municipal Link o Resource Person sa kanilang pangangasiwa sa buwanang FDS at paghikayat sa mga benepisyaryo na isabuhay ang kanilang mga natutunan mula rito. Ito ay nahahati sa mga sumusunod na Modyul

Modyul 1: Paglalatag ng Pundasyon ng Pantawid Pamilyang Pilipino Program

Ang Modyul na ito ay tumatalakay sa kabuuang perspektibo ng Pantawid Pamilya bilang isang pambansang programa na naglalayong tulungang paangatin ang buhay ng mga mahihirap na sambahayan sa ating lipunan. Partikular na tinatalakay rito ang layunin at tunguhin ng programa at ang mga kondisyon na kailangang tugunan ng mga kasaping benepisyaryo ng Pantawid Pamilya. Kasama rin sa bahaging ito ang pag-alam sa mga prinsipyong gumagabay sa pagpapatupad ng Programa at ang pagkilala sa karapatan ng mga babae, bata at ang mga Katutubong Pilipino.

Modyul 2: Paghahanda at Pangangalaga ng Pamilyang Pilipino

Ang Pangalawang Modyul naman ay naglalayong palakasin at patatagin ang mga pamilya upang sila ay maging aktibong kalahok sa pagtataguyod ng pagbabago ng kanilang kalagayan. Ang Modyul na ito ang may pinakamahabang sakop na paksa tungkol sa pamilya. Sinisimulan nito ang pagtalakay sa paghahanda ng pamilya at pagsubaybay sa paglaki ng mga bata. Binibigyang-diin ng mga paksang ito ang responsibilidad ng mga magulang sa kanilang anak at ang pagtukoy sa mga kasalukuyang batas na nagbibigay-proteksyon sa mga bata laban sa anumang uri ng karahasan, pangaabuso at pagsasamantala.

Modyul 3: Partisipasyon ng Pamilyang Pilipino sa Gawaing Pangkomunidad

Ang huling Modyul ay naglalaman ng mga paksang tumatalakay sa mga usaping pangkomunidad na maaaring gamiting behikulo para pakilusin at palahukin ang mga sambahayang pamilya sa mga gawaing pampaunlad ng komunidad.

j. Parent Effectiveness Service (PES)

The DSWD's Parent Effectiveness Service is the provision and expansion of knowledge and skills of parents and caregivers on parenting to be able to respond to parental duties and responsibilities in the areas of early childhood development, behavior management of younger and older children, husband-wife relationships, prevention of child abuse, health care, and other challenges of parenting. It assists parents and parent-substitutes so they can assume the major educational role in the growth and development of children. PES uses a Manual on Effective Parenting for fathers, mothers, surrogate parents and caretakers of children 0-6 years old and older. DSWD uses the Parenting the Adolescent Manual (PAM) for parents of adolescents.

k. Parenting the Adolescent Manual (PAM)

The PAM was conceived and developed in the spirit of the Parent Effectiveness Service or PES, a program initiated by the Department of Social Welfare and Development to guide parents through the process of raising healthy, productive and responsible children.

Modules 1 and 2 allows parents to tune in to themselves and reflect on their current situations. It is hoped that awareness of who they are and understanding what they want will make parents decide on what to do and how to resolve their personal concerns. In Modules 3, 4, and 5, parents discuss the changes in their children as they become adolescents and the adventures that they are likely to get involved in. Parents are given guidelines on what to do, how to relate with their adolescents in different situations. These three modules teach parents how to befriend their adolescent. In Module 6, parents and their adolescents are encouraged to open themselves to others, to their community in particular, for mutual protection and peace of mind.

l. Learning Package on Parent Education on Adolescent Health and Development (LPPEd)

POPCOM's Parent Education classes aim to equip the parents and educate them with the necessary knowledge on sexuality and other health related concerns of adolescents and skills on communicating such concerns to their children and highlight the role of parents as primary source of accurate and sound information on adolescent health and development. It contains the following modules:
• Me as Parent
• Me and my Family
• Knowing and Understanding my Adolescent
• Building a Positive Relationship with my Adolescent
• Harnessing my Adolescent with Life Skills

m. Peer Education: U4U (You for You) Teen Trail

Launched by the Commission on Population (POPCOM) and the UN Population Fund (UNFPA) in 2014, U4U is an initiative aiming to deliver critical information to Filipino teens aged 10-19 years old to prevent or reduce the incidence of teen pregnancy and sexually transmitted infections including HIV/AIDS. There are four U4U platforms:
• Teen Trail is a teen caravan that is set up in schools and communities and managed by teens themselves. It includes interactive exhibit, fun workshops, songs and dances
• Online Portal (www.u4u.ph) is a dynamic and interactive website that allows teen users to learn about self-identity, life skills, friendships and health advocacy among others.
• Social Media (www.facebook.com/U4U.ph)
• Interactive Voice Response System (IVRS) is an automated mobile service that gives recorded information to teens who send a "U4U" text message to dedicated mobile phone numbers

n. Sexually Healthy and Personally Effective (SHAPE) Adolescent Training Package

POPCOM's training tool for adolescents and youth aims to increase the awareness of young people on issues and concerns affecting them particularly on sexual and reproductive health and equip young people with practical life skills to be able to deal with the demands of everyday life. Currently, SHAPE is being updated to incorporate the notable changes in the environment where young people are situated (e.g. prevalent use of cell phones, and internet that includes social networking).

o. Youth Development Sessions (YDS)

NYC produced these modules for youth development. Bata Bata Magkano Ka Ginawa? The Cost of Teen Pregnancy Session Content: Risks and Costs of Teen Pregnancy Financial cost of pregnancy Risks of teen pregnancy Social consequences of adolescent pregnancy.

Core Message: Teen Pregnancy is risky and costly. Iba na ang ready. Lamang ang may alam. Objectives: At the end of the two- hour session, the participants shall be able to:

• Identify the care and medical needs and corresponding expenses for a healthy
• pregnancy and baby
• Enumerate the risks of teen pregnancy
• Recognize their financial preparedness and physical readiness to bring a child
• into the world
• Know the social implications of teen pregnancy

p. Kuwentong Buhay, Kuwentang Buhay:

Changing Selves, Changing Lives
Session Content: Psychological development and risky behaviors among adolescents
Core Message: May tamang panahon para sa lahat. Huwag sayangin ang pagkakataon.
Objectives: At the end of the two- hour session, the participants shall be able to:

• Be self-aware and realize the biological, emotional and behavioral development happening to them
• Distinguish differences between positive risk and negative risk
• Identify risky behaviors among adolescents

Annex D

Collated Menu of Global AHDP Indicators and definitions

Estimated Adolescent Population as Proportion of Total Population (PSA 2010)

Age/ Sex	Male	Female	Total
10-14 years	5.3%	5.1%	10.4%
15-19 years	5.2%	5.0%	10.2%

Example: To compute for the estimated population of females' age 10-19 years, multiply total (all ages, male and female) population by 0.101.
Total population 1,000,000 * 0.101 = 101,000 women 10-19 years old

Indicator	Description	Calculation		Possible Sources of Data
		Numerator	**Denominator**	
Age-specific fertility rate (Adolescent birth rate)	Births among adolescents	# livebirths to women 10-19 years old	# total population of women 10-19 years old	Civil registry and/or midwives master list
Repeat pregnancies	Percentage of all adolescent pregnancies that are the second, third or more for the adolescent	# pregnant adolescents who have had at least one pregnancy prior to this pregnancy	# total pregnancies among adolescents	Civil registry and/or midwives master list
Drop-outs due to pregnancy	Adolescent girls who drop out of school when they get pregnant	# currently pregnant adolescents who drop out of school		DepEd, schools or midwives master list
Proportion of adolescents who have ever had sex	Percentage of all adolescents who report that they have had sex at least once in their lifetime	# adolescents who have had sex	# total population of adolescents who answered the survey	Survey YAFSS
Median age of first sex	Age at which half the sample have had sex at a younger age and half the sample have had sex at an older age			Survey YAFSS
Proportion of adolescents who have had sex in the past 6 months	Percentage of all adolescents who report that they have had sex at least once in the 6 months prior to the survey	# adolescents who have had sex in the past 6 months	# total population of adolescents who answered the survey	Survey YAFSS
Proportion of sexually active adolescents who used a condom during their latest sexual encounter	Percentage of adolescents who have had sex and reported used a condom during their latest sexual encounter	# adolescents who used a condom during their latest sexual encounter	# adolescents who have had sex	Survey YAFSS
Proportion of adolescents who have used harmful substances (drugs, alcohol, tobacco)	Percentage of all adolescents who report having used drugs/ alcohol/ tobacco	# adolescents who used drugs/ alcohol/ tobacco	# total population of adolescents who answered the survey	Survey YAFSS, GSHS, GYTS

Proportion of adolescents who have experienced gender-based violence	Percentage of all adolescent females, or lesbian, gay, bisexual, or transsexual (LGBT) who have experienced any acts of violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life, because they are women or LGBT	# adolescents who reported having experienced GBV at least once in their lifetime	# population of adolescents who answered the survey and are women or LGBT	Survey YAFSS
Proportion of adolescents who have ever had symptoms of depression and/or suicidal ideations	Percentage of all adolescents who have felt sadness or loneliness severe enough to affect their usual activities or have had thoughts of harming or killing themselves	# adolescents who report having symptoms of depression and/or suicidal ideations	# total population of adolescents who answered the survey	Survey YAFSS
Proportion of adolescents who are underweight	Percentage of adolescents who are below the 10th percentile of weight-for-age according to the WHO growth reference for school-age children and adolescents	# adolescents below 10th percentile of weight-for-age	# total population of adolescents who participated in the survey	Survey NNS
Proportion of adolescents who are overweight and obese	Percentage of adolescents who have a Body-Mass Index (BMI) greater than or equal to 25	# adolescents who have a BMI greater than or equal to 25	# total population of adolescents who participated in the survey	Survey NNS
Proportion of adolescents who have participated in at least one community activity in the past 6 months	Percentage of adolescents who report having participated in at least one activity for the benefit of their community, such as (but not limited to) peer education, cleanliness drive, voters education, and other volunteer activities in the 6 months prior to the survey	# adolescents who have participated in at least one community activity in the past 6 months	# total population of adolescents who answered the survey	Survey
Proportion of adolescents with PhilHealth coverage	Percentage of adolescents who are PhilHealth members either as dependent, employed, or individually-paying	# adolescents who are PhilHealth members	# total population of adolescents	PhilHealth

Menu of Indicators

Indicator	Possible Sources of Data
Behavior	
Number of adolescents availing of adolescent-friendly reproductive and sexual health services	Health centre data
% of pregnant adolescents with 4 or more prenatal visits	Health centre data
% deliveries of adolescent mothers done in a health facility	Hospital data
% contraceptive rate among post-partum adolescents	Health centre data
% of adolescents who received vaccines	Health centre data
% of adolescents who seek reproductive health services from government facilities	Health centre data
Number of adolescent who sought psycho-social consult and mental health care in private and public hospitals	Hospital data
Number of youth-led organizations (with adolescent officers and members)	Environmental scan
Early sexual debut (measured as median age at first sex)	Survey
% of adolescents who had sexual relations with more than 1 partner in the last 12 months	Survey
% of adolescents who engage in unprotected sex	Survey
% of Adolescents who have sex for money or other forms of exchange	Survey
Number of induced abortions among adolescents	Survey
% of adolescents who engage in cybersex	Survey
% prevalence rate of dangerous drug use among adolescents	Survey
% prevalence of alcohol beverage drinkers among adolescents	Survey
% currently use any tobacco product	Survey
% of never smokers are likely to initiate smoking next year	Survey
% want to stop smoking	Survey
% tried to stop smoking during the past year	Survey
% have ever received help to stop smoking	Survey
% of adolescents who ride vehicles driven by a driver who has been drinking alcohol	Survey
% of adolescents who incurred injuries due to risky road behavior (no seatbelt, no helmet, driver who has been drinking alcohol	Survey
Protection	
% of adolescents who developed injuries from violent events	Survey
% of mortality of adolescents who developed illnesses &/or injuries from working in hazardous workplaces	Survey
% of adolescents who are culturally bound to child marriage	Survey
Service Delivery	
% of retained hospitals, provincial/ district hospitals, and rural health units certified as Adolescent-Friendly	Environmental scan

Capacity Building	
% RHU midwives, nurses, and doctors who say they are confident that they can talk to adolescents about sex, suicide, substance abuse, and other topics	Survey
Number of parents, teachers, local government service providers, police, barangay tanod, civil society organizations, and faith-based organizations who say they are confident to talk with adolescents about health issues	Survey
Number of youth-led advocacy initiatives	Environmental scan
Number of project proposals from youth organizations that are funded	Environmental scan
Program Sustainability	
Funding: A strategy to ensure sustainable financing of the AHDP is developed	Environmental scan
M&E: An effective system for gathering and accessing reliable and accurate information for programming decisions is in place	Environmental scan
Research: Current gaps in data are addressed by research endeavours	Environmental scan
Partnerships: Stakeholders express support for AHDP Strategic Plan	Environmental scan
Policy advocacy: LGU passes or enforces ordinance on AHDP	Environmental scan
Policy advocacy: LGU provides funding for AHDP	Environmental scan

Annex E

Program Monitoring and Reporting Forms

AHDP Monitoring Tool

ADOLESCENT HEALTH AND DEVELOPMENT PROGRAM: *Regional Monitoring Tool*

Health and non-health workforce

Indicator	Male	Female	Total
# of personnel trained in AJA			
Doctor			
Nurse			
Midwife			
Peer educator			
Others (e.g. teachers, RSW)			
# of personnel trained in ADEPT			
Doctor			
Nurse			
Midwife			
Peer educator			
Others (e.g. teachers, RSW)			
# of people trained in the use of Health Young Ones			
Health care providers			
Adolescents			
Others (e.g. teachers, RSW)			

Facilities, Logistics, and Commodities

#	Indicator	Total # of facility	Level 1 #	Level 1 %	Level 2 #	Level 2 %	Level 3 #	Level 3 %
5	% of AFHF							
a	CHO							
b	RHU							
c	DOH-retained hospital							
d	Teen centers							
	i. School							
	ii. Community							
e	Others							

Services

#	Indicator	Male 10-14	Male 15-19	Female 10-14	Female 15-19	Total
6	# of people given information using HYO					
a	Adolescents					
b	Parents (all ages)					
c	Health care providers (all ages)					
7	# of adolescents assessed using HEEEADSSSS tool					
8	% adolescents referred to appropriate services among those with health risk					
a	N: # referred to appropriate services					
b	D: # of adolescents with health risk					
8.1	# of adolescents who went to the facility to access services among those referred through HEADSS					

Adolescent Participation

Indicator	Male	Female	Total
# of adolescents with capacity to provide health information, life skills training, and referral			
10-14			
15-19			
By type of facility			
Number of health facilities with adolescent volunteers			
RHU			
Teen centers			
i. School			
ii. Community			
Others			

Financing, Policy, and M&E

#	Indicator	
9	Total expenditure per year of the regional AHDP	Php _____
10	Service Delivery Network for adolescents available?	
a	Regional	Yes / No
b	Local (LGU)	LGUs with SDN: ____ / Total # of LGUs: ____
11	# of policies that promote adolescent health and their access to services	# of Policies: _____
12	Sex- and age-disaggregated data, specifically on adolescents 10-19 years old available?	Yes / No

Annual Scorecard A: Adolescent Health and Development Program (AHDP) indicators

ANNUAL SCORECARD A: Adolescent Health Program Indicators

#	Health systems indicators	National Base line	2018	R1	R2	R3	R4A	R4B	R5	R6	R7	R8	R9	R10	R11	R12	NCR	CAR	CAR AGA	AR MM
1a	# AJA-trained																			
1b	# ADEPT-trained																			
2a	# HYO-trained HCP																			
2b	# HYO-trained adolescents																			
3	% AFHF																			
4	# capacitated adolescents																			
5	# facilities with adolescent volunteers																			
6a	# adolescents given HYO																			
6b	# parents given HYO																			
6c	# HCPs given HYO																			
7	# assessed using HEADS																			
8	% adolescents referred																			
8.1	# adolescents went to HF																			
9	Total expenditure																			
10	% regions with adolescent SDN																			
	a. Regional																			
	b. Local (LGU)																			
11	# of policies for adolescent health																			
12	% regions w sex- & age- disagg. Data																			

Annex F

Adolescent–inclusive Minimum Initial Service Package (MISP) Services for Reproductive Health in Crisis Situations MISP

From the Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: A Companion to the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings. UNFPA. September 2009.

Subject Area	MISP SRH Services	Planning for Comprehensive SRH Services
Family Planning (FP)	• Source and procure contraceptive supplies. • Although comprehensive family planning is not part of the MISP, make contraceptives available for any demand. • Health staff should be aware that adolescents requesting contraceptives have a right to receive these services, but need their parents' consent, if a minor.	• Provide staff training • Establish comprehensive family planning programming • Provide community education • Ensure that a broad mix of free FP methods is available • Provide community information, education and communication (IEC) directed toward adolescents • Involve adolescents, parents and community leaders in development of IEC strategy for FP in the community • Train staff in adolescent-friendly FP service provision • Promote the use of dual protection (prevention of pregnancy and prevention of STIs, including HIV)
Gender-Based Violence (GBV)	• Coordinate and ensure health sector prevention of sexual violence • Provide clinical care for survivors of sexual violence • Provide adolescent-friendly care for survivors of sexual violence at health facilities • With the Protection Cluster and GBV sub-Cluster, identify a multi-sectoral referral network for young survivors of GBV • Encourage adolescent participation in any multi-sectoral GBV prevention task force • Through adolescents, raise awareness in community about the problem of sexual violence, strategies for prevention, and care available for survivors • Engage traditional birth attendants (TBAs) and community health workers (CHWs) to link young survivors of sexual violence to health services	• Expand medical, psychological, social and legal care for survivors • Prevent and address other forms of GBV, including domestic violence, forced/early marriage, trafficking, etc. • Provide community education • Involve adolescent leaders, parents and community leaders in the development of strategies to prevent GBV in the community • Involve youth in community education on prevention of GBV • Raise awareness in community about the problem of GBV, strategies for prevention, and help available for survivors • Sensitize uniformed men about GBV and its consequences • Establish peer support groups

Maternal and Newborn Care	• Establish 24/7 referral system for obstetric emergencies • Provide midwife delivery supplies, including newborn resuscitation supplies • Provide clean delivery packages • Provide adolescent-friendly services at health facilities • Coordinate with the Health Cluster and other sectors to identify pregnant adolescents in the community and link them to health services • Engage TBAs and CHWs to link young mothers to health services • Encourage facility-based delivery for all adolescent mothers	• Provide antenatal care • Provide postnatal care • Train skilled attendants (midwives, nurses and doctors) in performing Emergency Obstetric and Newborn Care (EmONC) • Access to basic EmONC and comprehensive EmONC increased • Raise community awareness about the risks of early motherhood and the importance of skilled attendant (facility) delivery • Integrate mental health and psychosocial support services for adolescent mothers
STIs, Including HIV Prevention and Treatment	• Provide access to free condoms • nsure adherence to standard precautions • Assure safe and rational blood transfusions • Although comprehensive STI programming is not part of the MISP, it is important to make syndromic treatment available for clients presenting for care as part of routine clinical services • Although providing anti-retroviral therapy (ART) continuation is not part of the MISP, it is important to make treatment available for patients already taking anti-retrovirals (ARVs) including for prevention of mother-to-child transmission (PMTCT) as soon as possible. • Provide discreet access to free condoms at adolescent-oriented distribution points • Ensure that adolescent-friendly health services are available for adolescents presenting to facilities with symptoms of STI	• Establish comprehensive STI prevention and treatment services, including STI surveillance systems • Collaborate in establishing comprehensive HIV services as appropriate • Provide care, support and treatment for people living with HIV • Raise awareness of prevention, care and treatment services for STIs, including HIV • Raise awareness of prevention and treatment services for STIs/HIV among adolescents • Train staff to provide adolescent-friendly STI and HIV-related services • Establish programs, including peer education, to adolescents most-at-risk for acquiring and transmitting HIV

Annex G

National Standards for Adolescent-friendly Services

Use this checklist to identify gaps in quality, adolescent-friendly health services in barangay health stations, rural health centers, and hospitals. This can also be used as a guide for teen centers in the community and school.

Standard	Input Criteria	Yes	No
1. Adolescents in the catchment area of the facility are aware about the health services it provides and find the health facility easy to reach and obtain services from it.	**Basic**		
	1. Inform adolescents of the availability of services		
	2. Signboard which indicates the type of health services that are provided, when they are provided, and that adolescents are welcome		
	3. Health services to adolescents free of charge or at affordable prices are in place		
	Enhanced		
	4. Flexible time schedule for adolescent clients		
	5. Provide outreach health services to adolescents, particularly those belonging to special groups		
2. The services provided by health facilities to adolescents are in line with the accepted package of health services and are provided on-site or through referral linkages by well-trained staff effectively	**Basic**		
	6. Package of services provided to adolescents		
	7. Essential commodities and supplies		
	8. Designated focal person for adolescent-friendly health services		
	9. Service providers have been trained and are competent in managing adolescent clients		
	10. Protocols / guidelines to provide services in non-judgmental, caring, considerate, gender and culturally-sensitive attitude and manner		
	11. Clinical management guidelines for the provision of the specified health services (Adolescent Job Aid)		
	12. Resource directory of organizations and referral networks		
	13. System and forms for referral and return referral		

Standard	Input Criteria	Yes	No
3. The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable	**Basic**		
	14. Facility: • comfortable seats with proper ventilation and good lighting • clean toilets • appealing materials (such as comics, brochures, services, survey results) to browse through while waiting		
	15. Confidentiality and privacy policy of the facility is clearly displayed in the clinic and is clearly expressed to the client and their parents or accompanying adults		
	16. Protocols for the staff to provide services in a friendly and appropriate manner so that both health-care providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.		
	17. Mechanisms to involve adolescents in the designing, provision and assessment of health services		
	18. Design for smooth patient flow and short waiting time		
	Enhanced		
	19. Facility: • clean drinking water • separate toilet for females • a computer/TV monitor and a player where a video material can be shown while waiting		

Standard	Input Criteria	Yes	No
4. An enabling environment exists in the community for adolescents to seek and utilize the health services that they need and for the health care providers to provide the needed services	Basic		
	20. Procedures to communicate with all adults visiting the health facility about the value of providing adolescents with services		
	21. Some health services and commodities to adolescents provided by selected community members, NGOs, outreach workers and adolescents themselves		
	22. Advocating for support for provision of services for adolescents in the local development plan		
	Enhanced		
	23. Activities (including community assemblies, meetings with parents, group meetings and school visits) to engage community members in providing adolescent health services		
	24. The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.		

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

January 24, 2017

DEPARTMENT MEMORANDUM
No. 2017- _0098_

TO   :   **ALL REGIONAL DIRECTORS AND CHIEFS OF HOSPITALS**

SUBJECT: **Adolescent Friendly Health Facility Standard Evaluation Tool**

The Adolescent Friendly Health Facility (AFHF) standards were crafted by the DOH in collaboration with partner agencies working for and with adolescents. This was approved and disseminated to DOH regional offices nationwide in 2014. However, implementers at the local level are experiencing difficulty in operating the AFHF standards due to non-availability of space for health examination and counseling of adolescents, and financial and manpower constraints.

Thus, the Adolescent Health and Development Program of the Disease Prevention and Control Bureau developed the Adolescent Friendly Health Facility Standard Evaluation Tool (Levels 1-3) with specific criteria of carrying out the AFHF standards.

Attached are the tools to be used in evaluation of Adolescent Friendly Health Facility.

For strict compliance.

By Authority of the Secretary of Health:

GERARDO V. BAYUGO, MD, MPH, CESO III
Undersecretary of Health
Office for Technical Service

Building 1, San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila ● Trunk Line 651-7800 local 1113, 1108, 1135
Direct Line: 711-9502; 711-9503 Fax: 743-1829 ● URL: http://www.doh.gov.ph; e-mail: officeofsoh@doh.gov.ph

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

Monitoring Tool 1. Facility Observation Checklist

Region: _____
Province: _____
Municipality:_____
Level 1 Health Facility

Adolescents in the catchment area of the facility are aware about the health services it provides and find the health facility easy to reach and to obtain services from it.

Item	Self Assessment		Assessment Team		Recommendations
	YES	NO	YES	NO	
Welcome Signage					
Schedule of Clinic Hours (Day and Time)					
Health Services are provided	Specify: - _____ - _____ - _____ - _____ - _____		Specify: - _____ - _____ - _____ - _____ - _____		
Clinical Guidelines in the provision of Adolescent-Friendly Health Services					
Registration logbook containing the list of clients who consulted and were given services					
List of services provided by the facility					
There is a designated person with access to the records.					
There is a designated room/space for client – provider interaction with chairs, tables, well ventilated and well lighted					

Monitoring Team: Date and Time of Monitoring:_____
_____
_____
_____

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Monitoring Tool 2. Facility Observation Checklist

Region: _____
Province: _____
Municipality:_____
Level 2. Health Facility
*In addition to the minimum standards set for Level 1 Health facilities.

"The services provided by health facilities to adolescents are in line with the accepted package of health services and are provided on site or through referral linkages by well-trained staff effectively".

Item	Self Assessment		Assessment Team		Recommendations
	YES	NO	YES	NO	
National Standards for Adolescent Service Package					
Action Plan for Information Dissemination					
Policy regarding flexible time schedule					
Policies for provision of services					
Policies for payment schemes					
Plan for outreach program / Advocacy campaign					
IEC materials on the different programs / services available (Example IEC on maternal care, family planning, etc) displayed on a rack / conspicuous place. The IEC materials should also include the directory of other agencies/organizations where the services can be obtained and referral forms.					
There are separate rooms for consultation, treatment and counseling. If there are limited rooms, there are at least curtains to separate each provider. * Conversation between provider and client cannot be heard by others.					
Certificates of training on the minimum training courses prescribed by DOH for adolescent focal persons and other providers					

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*Comprehensive Mgt of Adolescent Training for HSP				
Protocols and guidelines for patient-provider interaction				
Policies and procedures to ensure privacy and confidentiality is posted				
Individual records are kept in separate envelopes.				
All records are kept in a safe place, preferably in a separate room or a filing cabinet with lock and key.				
Individual Treatment Records that shows the chief complaint, findings on examination, clinical impression and management of clients				
Directory of organizations – name, address, services provided, contact number and contact person (for referral)				
Referral logbook – name, age, address, Clinical Impression, where referred, reason for referral, result of referral				
Referral forms				
Accomplishment report showing the services given at the public health facility as well as those given by other agencies, individuals and peer counselors				

Monitoring Team: Date & Time:_____

_____
_____
_____

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Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

Monitoring Tool 3. Facility Observation Checklist

Region: _____
Province: _____
Municipality: _____

Level 3. Health Facility

*In addition to the minimum standards set for Level 1 and 2- Health facilities.

The health services are provided in ways that respect the rights of adolescents and their privacy and confidentiality. Adolescents find surroundings and procedures of the health facility appealing and acceptable".

Item	Self Assessment		Assessment Team		Recommendations
	YES	NO	YES	NO	
Patient flow from admission to delivery of services including the average time for each step is posted in strategic places.					
Stock cards showing the delivery and utilization of medicines, commodities for adolescent health care					
There is a suggestion box.					
There are peer educators assisting in clinic operations and providing services (lectures, counseling, etc)					
Materials being used by the adolescents in the facility *Educational materials, musical and sports instruments, etc					
SOP for maintenance of facility					
Schedule of meeting of TWG					
Minutes of meetings of TWG					
There is a designated person with access to the records.					
There are leaflets containing the clinic schedule and services which the patients/community members can bring home and share to other community members.					
IEC Plan					

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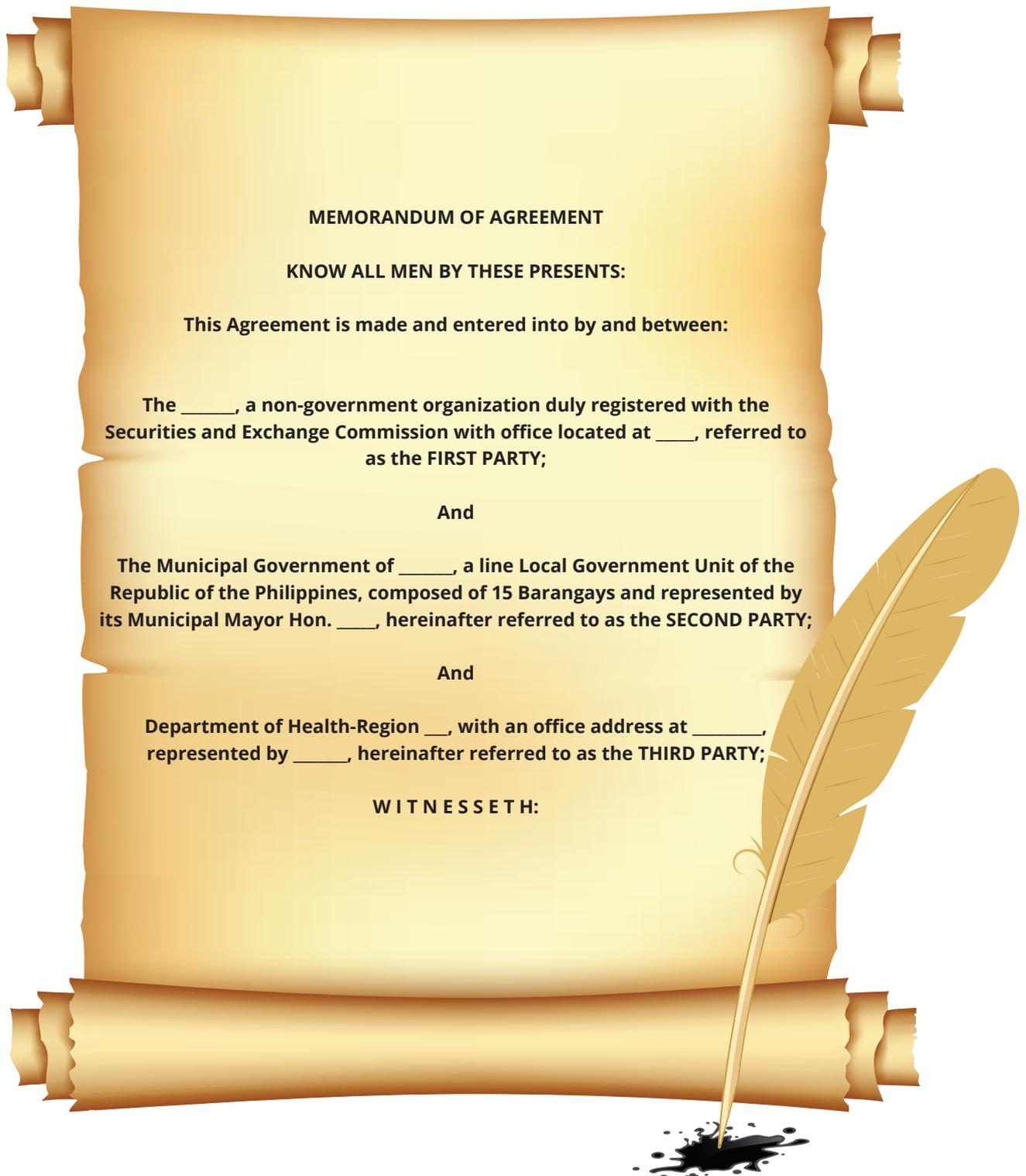|					
Copy of the Local Development Plan					
Advocacy Plan					
Action Plan showing different agency participation – the name of the agency, resources/assistance they will provide, the person's responsible					

Monitoring Team: Date & Time:_____

_____

_____

_____

Annex H

Sample Memorandum of Understanding/Agreement (MOA)

MEMORANDUM OF AGREEMENT

KNOW ALL MEN BY THESE PRESENTS:

This Agreement is made and entered into by and between:

The _____, a non-government organization duly registered with the Securities and Exchange Commission with office located at _____, referred to as the FIRST PARTY;

And

The Municipal Government of _____, a line Local Government Unit of the Republic of the Philippines, composed of 15 Barangays and represented by its Municipal Mayor Hon. _____, hereinafter referred to as the SECOND PARTY;

And

Department of Health-Region ___, with an office address at _____, represented by _____, hereinafter referred to as the THIRD PARTY;

W I T N E S S E T H:

WHEREAS, Having taken effect on January 17, 2013 in large part due to the strong advocacy of stakeholders and the commitment of Government, Republic Act No. 10354 or "The Responsible Parenthood and Reproductive Health Act of 2012" (RPRH Act) has become the focal point for convergence of multi-sectoral efforts toward the improvement of health outcomes;

WHEREAS, Partnership with local governments as lead implementers of basic health services is central to the success of the RPRH Act, hence the active participation in the process of implementing rules and regulations (IRR) drafting and commitment to implementation thereof by the League of Provinces of the Philippines; the League of Cities of the Philippines; and the League of Municipalities of the Philippines;

WHEREAS, SECTION 3.01 (F) Civil Society Organizations (CSOs) refer to nongovernment organizations (NGOs), People's Organizations (POs), cooperatives, trade unions, professional associations, faith-based organizations, media groups, indigenous peoples movements, foundations, and other citizen's groups which are non-profit and formed primarily for social and economic development to plan and monitor government programs and projects, engage in policy discussions, and actively participate in collaborative activities with the government.

WHEREAS, the Elements of the Responsible Parenthood and Reproductive Health Act of 2012 (Republic Act No. 10354) are Family Planning information and services, maternal, Infant and Child health and nutrition Including breastfeeding, Proscription of Abortion, and management **of Abortion complications, adolescent and youth reproductive health guidance and counselling, prevention, treatment and managements of reproductive tract infections, HIV and AIDS, Elimination of violence against women and children, age development – appropriate education and counselling on Sexuality and RH**, treatment of Breast and reproductive tract cancers and other gynaecological conditions and disorders, male responsibility and involvement and men's RH, Prevention treatment and management of infertility and sexual dysfunction, **age development appropriate RH education for adolescents in formal and non- formal educational settings** and mental health aspect of reproductive health care.

WHEREAS, to complement in the provision of age- and development appropriate reproductive health education and services among young people, the **First Party** is implementing a project entitled "_____" with a funding support from the _____;

WHEREAS, the **SECOND** and **THIRD PARTIES** agree to support the **First Party** in the implementation of the

Project which will serve as a model communities for the implementation of this pilot activity in Region ___;

NOW THEREFORE, for and in consideration of the foregoing, the **FIRST PARTY**, **SECOND PARTY and THIRD PARTY** agree as follows:

SECTION I. COMMITMENTS AND RESPONSIBILITIES OF THE PARTIES

11.   **FIRST PARTY**

The _____, a member of the _____, shall be responsible for providing orientations, technical assistance and support to the "**Second Party** and **Third Party**" and will ensure that the project is well implemented. The "First Party" is responsible of the following:

12.   Provide Medical outreach with health information session every month to the target communities, targeting the young key affected population (YKAPS) adolescents (12-19 yrs. Old) like Teenage moms.

13.   Provide Information Dissemination "_____ session" with coordination with the LGU and BLGU's to the adolescents.

14.   Capacitate young volunteers to help for the implementation of the Medical Outreach and _____ session.

15.   Coordinate with the 2nd and 3rd parties in the conduct of the different project activities in the pilot areas.

16.   Conduct regular joint monitoring and evaluation activities together with the _____ national office, DOH ___ and MHO in implementation of the project.

17.   Prepare and consolidate reports submitted by the project staffs to be forwarded to the **Second** and **Third Party** for references and other purposes.

18.   The project team shall meet regularly (once a month) or as need arises to ensure regular coordination and reporting activities.

19.   **SECOND PARTY**

20.   Provide policy support for the implementation of the project;

21.   Provide Technical assistance to the whole duration of the project.

22.   Ensure participation of Public and private partnership.

23.   Conduct monitoring and evaluation of the project for quality assurance for replication;

24.   Designate "Focal Persons" to assist the Project Team, and to sit as members of the Project TWG for coordination and dissemination of project information;

25.   **THIRD PARTY**

26.   Assist and monitor the implementation of "_____"

D.   **ALL PARTIES** agree that in case of dispute arising from this agreement, the provisions of Book IV, Chapter 14 of Executive Order No. 292 otherwise known as the Administrative Code of the Philippines shall apply;

27.   That the parties have further agreed to comply with this Memorandum of Agreement (MOA) in good faith and the same is further subjected to any law, customs, good morals and public policy that might render any of the provisions of this MOA to be ineffective and without any force as may be declared by any competent court.

SECTION II. EFFECTIVITY

That this MOA shall take effect upon the signing of the parties hereof and shall remain valid until December 31, 2015 unless otherwise terminated or renewed as may be agreed upon proper notice by the parties;

SECTION III. AMENDMENT OR TERMINATION

Amendment/s to this Agreement shall be subject to the mutual consent of all parties and/or unless either party wishes to terminate the agreement. Written notice to all parties must be made at least thirty days prior to amendment/s or termination of the agreement.

IN WITNESS WHEREOF, All Parties hereby set their minds and hands this _____ at _____.

_____   Hon. _____
     First Party   Second Party

_____
     Third Party

Signed in the Presence of:

_____   _____

ACKNOWLEDGEMENT

REPUBLIC OF THE PHILIPPINES)
CITY OF _____) S.S.

BEFORE ME, a Notary Public in and for the City of _____, personally appeared on this ____ day of _____ 2015:

Name/s   CTC No.   Place and Date of Issue

all known to me to be the same persons who executed the foregoing instruments, and that they respectively acknowledged that the same is their free and voluntary act and that they presented to me at least one current identification document issued by an official agency , said identification document contains the photograph and signature of the affiants.

This instrument, consisting of five (5) pages, including the one on which this acknowledgment is written, has been signed on the left margin of each and every page thereof by the respective parties and their witnesses and sealed with my notarial seal.

WITNESS MY HAND AND NOTARIAL SEAL.

Doc. No. _____

Page No. _____

Book No. _____

Series of _____

Annex I

Sample Forms

a.   Client Satisfactory Survey

ADOLESCENT CLIENT SATISFACTION SURVEY

Thank you for accessing our services!
We hope you can answer this short survey to help us improve in the future.

Name of Facility: _____   City: _____

Age: ____   Sex: M F   Average Rating: _____

1.   What service/s did you avail? *(List below)*

Check the box that corresponds to your answer.

	1	2	3	4
	Strongly Disagree	Disagree	Agree	Strongly Agree
2. Services were helpful				
3. Explanations were understandable				
4. Service providers made me feel welcome				
5. I was assured that info will be confidential				
6. I did not feel judged or discriminated				
7. I would avail this service again				
8. I would recommend my friends to come here				

HIV and ADAP Form   *Page 1 of 1*

ADOLESCENT CLIENT SATISFACTION SURVEY

Thank you for accessing our services!
We hope you can answer this short survey to help us improve in the future.

Name of Facility: _____   City: _____

Age: ____   Sex: M F   Average Rating: _____

1.   What service/s did you avail? *(List below)*

Check the box that corresponds to your answer.

	1 Strongly Disagree	2 Disagree	3 Agree	4 Strongly Agree
2. Services were helpful				
3. Explanations were understandable				
4. Service providers made me feel welcome				
5. I was assured that info will be confidential				
6. I did not feel judged or discriminated				
7. I would avail this service again				
8. I would recommend my friends to come here				

Client Satisfaction Survey adapted from UNICEF

b.   Sample Pre Test and Post –Test on Adolescent Job Aid or ADEPT Training

DEPARTMENT OF HEALTH
Adolescent Health Education and Practical Training (ADEPT) and Adolescent Job Aid Training (AJA) for Healthcare Service Providers

NAME: _____   SCORE: _____

POSITION/DESIGNATION: _____   DATE: _____

AREA ASSIGNED: _____

A.   Select and encircle the best answer:

1. Adolescent refer to the young people ages:
    a. 10-19 years old
    b. 15-24 years old
    c.10-24 years old
    d. 15-30 years old

2. Adolescence is:
    a. Transitional time between childhood and adulthood
    b. Tremendous physical and cognitive growth
    c. Time of risk-taking and opportunity
    d. All of the above
    e. None of the above

3. The following changes occur in early adolescence:
    a. Prefer their peer over their parent
    b. Physical changes like presence of acne, body odor, development of hair in parts of the body
    c. Start to seek who they are
    d. All of the above

4. The first sign of puberty in a male is:
> a. Height spurt
> b. Increase in skeletal size
> c. Changes in voice
> d. Increase in the volume of the testes

5. The first sign of puberty in a girl is:
> a. Increase in height
> b. First menstruation
> c. Breast budding
> d. Increase in hip curves

6. When do you ask for pelvic exam?
> a. Signs of vaginal infection (itching burning or unusual discharge)
> b.Vaginal bleeding not part of normal menstrual period
> c. Pain in her belly or pelvis
> d. All of the above
> e. None of the above

7. We need to focus on adolescent nutrition because of the following EXCEPT:
> a. Adolescent is the second most critical period of growth and development in a person
> b. 25 % of an adult's final height occur during adolescence
> c. Malnutrition affects a person's ability to learn and to work productively
> d. It does not affect the obstetrical outcomes in the very young mother
> e. None of the above

8. What are the main causes of being overweight?
> a. Eating more food than what the body requires
> b. Less activities that use up calories
> c. Genetic predisposition
> d. Excessive use of alcohol
> e. All of the above

9. Give at least 5 characteristics of an Adolescent Friendly Health Facility:
> a. _____
> b. _____
> c. _____
> d. _____
> e. _____

10. Early pregnancy refers to pregnancy of girls less than 20 years old
> a. Yes
> b. No

11. The format of the adolescent-friendly encounter is:
> a. The adolescent is seen first then the parent comes in.
> b. The parent is seen first then the adolescent comes in.
> c. Both the parent and the adolescent are seen together then the parent steps out then comes back towards the end of the visit.
> d. Both the parent and the adolescent are seen then the adolescent steps out then comes back towards the end of the visit.

12. Give at least 5 package of services for adolescents provided by the RHU:
> a. _____
> b._____
> c. _____
> d. _____
> e. _____

B.   When to BREAK and KEEP Confidentiality

Direction: Put/write BREAK if the health care providers may need to break confidentiality, and put/write KEEP if the information may need to disclose to the parents / guardians.

a. When the patient discloses plans to commit suicide.
b. When the patient plans to hurt others.
c. When the parents are pressuring the doctor to disclose.
d. When the 17-year-old male comes in with an STI (sexually transmitted infection).
e. When the patient disclose that he has a same-sex partner.
f. When the patient experiments with tobacco.
g. When the 17-year-old female has a positive pregnancy.
h. When the 15-year-old female has sexual relations with a 25-year-old teacher.

C.   Arrange the steps in proper order:

What are the steps in an adolescent-friendly health encounter?

_____Ask the adolescent to introduce his/her companion.
_____Discuss the format of the visit, define confidentiality, and the need to see the adolescent alone to both the adolescent and the parent/companion.
_____Greet and introduce yourself to the adolescent.
_____Call back the parent/ companion and wrap up the consultation with both in [side] the room.
_____See the adolescent alone for the psychosocial interview.

D.   FILL in the BLANKS

Health care providers should be ready with a "form of words" when discussing confidentiality.

"I will keep our conversation _____ and will not pass information to your parents or any body else unless you give me _____.

"But I may have to break confidentiality and inform your parents and other doctors if I find out that you plan to _____ yourself or others and if you are experiencing physical or sexual ____."

E.   True or False

i. Privacy refers to the right of an individual to keep his/her information private._____
j. Confidentiality refers to the duty of a health care provider entrusted with health information to keep that information private._____

F.   Matching Type
Match the elements of an adolescent-friendly service in column A with the appropriate descriptions in column B.

Column A	Column B
____1. Accessibility	A. The facility has a well- trained staff.
____2. Appropriateness	B. The health facility is easy to reach.
____3. Affordability	C. Services address both the medical and psychosocial needs of the adolescents.
____4. Comprehensiveness	D. Services respond to the needs of adolescents.
____5. Efficiency	E. Free charge.

Checked by: _____
        Signature over printed Name

c. **Sample Pre-Test and Post – Test Forms on Health Education on HIV and AIDS**

HIV and AIDS <u>PRE-TEST</u> QUESTIONNAIRE

Please answer the questions below as best as you could. It is okay to make mistakes.
Lates, you will be given information on HIV and STI to correct any misconceptions.

Encircle the letter of the correct answer.

1. Untreated HIV infections will lead to AIDS.

   a. True   b. False   c. Don't know

2. Hiv may be passed on from one person to another person through all means, <u>EXCEPT.</u>

   a. Sexual intercourse without a condom
   b. Bloodd trasfusion of HIV-contaminated bloob
   c. Pregnant mother with HIV to her child
   d. Sharing of food with a person with HIV

3. A mother can trasmit HIV to her child through all means, <u>EXCEPT.</u>

   a. Pregnancyb. Delivery   c. Kissing her child   d. Breastfeeding

4. Can a healthy-looking person have HIV?

   a. Yes   b. No   c. Don't know

5. Can a person get HIV through mosquito bites?

   a. Yes   b. No   c. Don't know

6. Can HIV transmission be prevented by using condoms correctly and consistently?

   a. Yes   b. No   c. Don't know

7. Can a person get HIV by using public toilets?

   a. Yes   b. No   c. Don't know

8. Can HIV transmission be prevented by having sex with only one faithful partner who does not have HIV?

   a. Yes   b. No   c. Don't know

9. Can a person get HIV by sharing needles during injection of drugs?

   a. Yes   b. No   c. Don't know

10. There is NO CURE for HIV. But medicines called Antiretroviral Drugs are available for free in the Philippines to slow down the spread of HIV in the body.

     a. True   b. False c. Don't know

List the A, B, C, D, E of HIV prevention below.

A	
B	
C	
D	
E	

Please provide the information requests.

Facility: _____

City: _____

Age: _____   Sex: M   F

To be filled out by service providers:

VIC: _____

Test Score: _____

Pre and Post Test adapted from UNICEF Philippines

d.   Service Provider Self Assessment Form

<div align="center">

Staff Self-Assessment Form

Adolescent Health Care and Development Provider

</div>

Goal: Increase number of young people (10-19) years old Visiting the Health Center for consultation or asking information about adolescent health and issues.

Vision: Making Health Facility Adolescent Friendly

Mission: Insure that all adolescents have access to quality health care and services.

Evaluation/Item (for the facility)	Yes	No	Remarks
Facility			
Is the name of the facility visible?			
Are the clinic hours and services visible and clear to patients?			
Is there a waiting area for adolescents?			
Is there a suggestion box / board available?			
Is the policy to ensure confidentiality and privacy posted?			
Are there leaflets containing information (clinic schedules and services) available in the facility?			
Are there IEC materials regarding different programs/services available, including directory of other agencies/organizations where services can be obtained (e.g., HIV testing)?			
Are individual records kept in separate envelopes and kept in safe place?			
Are there separate rooms for consultation, treatment and counseling for adolescents? (Or if there are limited rooms, there are at least curtains to separate each provider?			
Are there peer educators assisting in the clinic operations and providing services (lectures, educating etc.)?			

Evaluation/Item (for the facility)	Yes	No	Remarks
Service Provider			
Did I greet the adolescent politely and make him comfortable?			
Did I introduce myself the teens and his/her companion?			
Did I call her by her name during the whole session?			
Did I reiterate /assure the importance of confidentiality and privacy to my patient?			
Did I ask permission from my adolescent patient when taking notes?			
Did I assure that no interruptions/phone calls that disrupt the patient during the interview?			
Did I allow the patient to talk freely?			
Is the examination area protected from view of other people?			
Did I ask/seek permission, inform, and explain the procedure of the medical examination?			
Prescribing a course of treatment			
Did I ask histories of allergies (food and drugs)?			
Did I explain what the treatment is all about and how it is taken (with written instructions)?			
Did I explain possible side effects and explain how to manage them?			
Ending the examination			
Did I summarize the most important information that the patient has to understand?			
Did I provide a two way referral slip and explain where, how, and when the client can go to avail of the needed services?			
Did we agree on the return visit?			
Did I assure the patient again that the discussion is confidential and private?			

_____

Health Care Provider

_____

e.   Referral Form

REFERRAL FORM (To be left in the Referral Facility)		
Reference number		
Name of Referring Facility: Address: Tel No:		
Name/Position of Service Provider Referring:		Date of Referral:
Name of the facility to which the client is being referred :		
Name of Client:		Age:
Address:		
Reason for Referral:		
Brief History (Include pertinent PE and laboratory findings and actions taken, if any.)		
Clinical Impression:		
Signature of Person Referring	Signature Over Printed Name of Client/Guardian:	
REFERRAL RETURN SLIP (Please cut and instruct patient/guardian to deliver back to Referring Facility)		

Reference Number -----	
Name of Referral Facility: Address: Tel No:	
Name/Position of Person Who Attended to the Patient:	Date Seen:
Final Diagnosis:	
Actions Taken (Include results of laboratory/ancillary procedures done and management) Follow up advice:	
Signature of Person Who Attended to the Patient:	Signature Over Printed Name of Client/Guardian:

Annex J

Sample activities and worksheets

Section 1 sample activities

HOW TO INTRODUCE THIS TOPIC TO STAKEHOLDERS

Use of body map or 'lumalaki-tumutubo-nagkakaroon' methods

Body Map
- Divide participants into groups of 4-8 people.
- (Optional) Give two large blank sheets of manila paper, markers and coloring materials
- Have them draw an outline of a boy and a girl (if unable to draw, have one of them lie down on a very large sheet of paper and trace around).
- Have them draw and label different changes that occur during adolescence both in males and in females.
- Discuss as a group.
- Note changes, including social, behavioural, and in the brain, that were missed. Fill-in the gaps. Also note that most of the changes occur in the genital areas.

Lumalaki-tumutubo-nagkakaroon
- Divide participants into groups of 4-8 people.
- Have them choose a male and a female model.
- Give blank stickers or sticky notes.
- Have them write down changes in adolescents as 'lumalaki' (enlarges), 'tumutubo' (grows), and 'nagkakaroon' (appears).
- Have them place the stickers in the appropriate parts of the body.
- Discuss as a group.
- Note changes, including social, behavioural, and in the brain, that were missed. Fill-in the gaps. Also note that most of the changes occur in the genital areas.

Section 2 sample activities

HOW TO INTRODUCE THIS TOPIC TO STAKEHOLDERS

Games to make the statistics more visual

Ilanang ...' (How many are ...')
- Divide participants into groups of 4-8.
- Give each group 20 pebbles, marbles, shells, coins (of the same denomination) or small paper cups (anything of equal sizes).
- Tell them this is going to test their arithmetic skills as well as their knowledge of the situation of adolescents.
- Tell him or her that each pebble, marble, shell, coin or cup represents 5 adolescents. So all in all, they have 100 adolescents in front of them.
- Let them know if the questions pertain to national, regional or local data and from what study the information comes from.
- Read or flash questions pertaining to the percentages. See background situation on health and development section.
- For example, *"If all those pebbles were in-school adolescents age 13-15, how many ... currently smoke."* (Note: Sample questions provided in Annex S)
- Have them lay out the corresponding number of pebbles in front of the group.
- A group representative can run to the front to pile the correct number of pebbles, with each group given a designated area for their pile. For example, the answer is 6.8%, so they should have laid out only one pebble.
- The team whose answer is closest to the correct one wins one point.
- Keep going until you run out of questions.
- The team with the most points wins.
- Discuss as a group. Do they believe the statistics? If you used national or regional data, do they think it is different for their locality? What did they learn about the magnitude of the different needs of adolescents?

HOW TO INTRODUCE THIS TOPIC TO STAKEHOLDERS

Before you introduce the Program Development Cycle, you can have them come up with their own program development process

- Prepare several sets of cards with the different steps/elements of the Program Development Cycle

- Divide the participants into groups of 4-8. Assign them each a separate space or table.

- Give each group a set of cards, arranged in no particular order.

- Have them arrange the cards in any form or shape they feel is the right order of tasks.

- After 5-10 minutes, have everyone go from table to table so each group can present their output. Why did they arrange it that way?

- Discuss as a big group. What was common among all the groups? E.g. everyone thought (correctly) that adolescents, parents, and the community should be involved all throughout the process or that all the diagrams were circular or iterative. Was there a step that was not in the cards but they felt should be included in the Program Development Cycle?

- Present the Program Development Cycle. Explain that in real life, it doesn't always proceed in this orderly fashion. However, you need to acknowledge that there are some steps that cannot be done easily or effectively without the information or decisions from the previous step. So, it is important to proceed in this strategic and deliberate manner to ensure that your program is responsive, effective, and able to achieve impact on adolescents' health and development.

Rights of adolescents

HOW TO INTRODUCE THIS TOPIC TO STAKEHOLDERS

Many of your stakeholders who have been working in adolescent health may already be familiar with the concept of child/adolescent rights, but some may not know these rights.

You can introduce this to stakeholders through a game:

- Divide the group into two. Have each side form a line facing each other.

- Toss a coin or use jack-en-poy to determine which side goes first.

- Have the first person in the first line name a right of adolescents or an obligation of the government or parents to adolescents.

- Have the first person in the other line name another right, without repeating any that has been previously mentioned.

- Keep going until the participants run out of answers. The team who said the last answer wins.

- Repeat the same process, but this time, have the participants name the responsibilities of an adolescent.

- Variation: Toss a ball between lines so instead of going by who is next in line, anyone in line can be the next to answer if the ball is thrown to her/him.

Program Matrix

HOW TO INTRODUCE THIS TOPIC TO STAKEHOLDERS

Unless stakeholders have done SWOT before, it is not recommended you ask them to accomplish the SWOT matrix. You might want to fill it in yourself, then present it to stakeholders to validate if these are accurate descriptions.

Adolescents, in particular, tend to think in terms of activities and implementation rather separating strategies from activities. So, you might want to take them straight to Step 5 (Develop an activity plan). The adults can continue with Step 4, noting what activities they have in mind for each strategy. Then bring them together in Step 5 and try to fit the adolescents' activities into the adults' strategies.

There may be activities in the list that do not fit into the prioritized strategies. Ask the group if they think they should add another or modify their strategies. If not, ask the adolescents if they want to proceed with the activity as a separate component or drop it for now. There may be strategies that the adolescents will not have corresponding activities for. Have the adults explain why this strategy is important. Then come up with activities as a group.

Health Outcome	Problem	Criteria 1 (low), 2 (moderate), or 3 (high)						Total Score
		Impact of the problem	Size or magnitude of the problem	Cost of intervention	Availability of Resources	Urgency of the problem	(You can insert additional criteria here)	
Healthy Nutrition	e.g. obesity	1	1	2	1	1		6 (lower priority)
	e.g. anaemia	2	3	1	1	2		8 (high priority
Sexual and Reproductive Health	e.g. early pregnancy	3	3	3	3	3		15 (highest priority)

1a: Priority Health Problems (blank)

Health Outcome	Problem	Criteria 1 (low), 2 (moderate), or 3 (high)				Total Score
		Criterion 1	Criterion 2	Criterion 3	Criterion 4	
Healthy Development						
Healthy Nutrition & Physical Activity						
Sexual and Reproductive Health						
Substance abuse						
Injuries						
Violence						

Mental health						
Services in crisis situations						
Supportive environment						
Increased service utilization						
Participation in community development						

2: SWOT Analysis (sample)

INTERNAL	
Strengths 90% of health staff trained in AJA One health centre per barangay Municipal hospital with 100 beds Peer educators trained by POPCOM	**W**eaknesses Turnover of health staff No budget for allowances of volunteers
Opportunities Many private doctors and midwives practicing locally 5 out of 12 city councillors are pro-RH Both Elementary and H.S. are near health centre School clubs conduct community service activities	**T**hreats 7 out of 12 city councillors are anti-RH
EXTERNAL	

2a: SWOT Analysis (blank)

INTERNAL	
Strengths	**W**eaknesses
Opportunities	**T**hreats
EXTERNAL	

3: Program Matrix (sample)

Narrative	Indicators and Targets	Source of Data	Important Assumptions
Vision (Goals) • Improved health status of adolescents • Adolescents fully enjoy their right to health			
Health Status (Outcome) 1: *Early pregnancies are reduced* • Contributing behavior& other factors: • Unprotected sex • Poor access to contraceptives • Alcohol and/or drug intake • Sexual abuse • Peer norms • Poor parental monitoring & communication • Lack of access to services & info	Decrease age-specific fertility rate from 57 to 54 live births per 1,000 adolescent women in 5 years	Civil Registry	Continued implementation of the RPRH Law

Instructions:

- The Narrative describes what you want to see or happen. The vision (goals) are given because this is the vision of the national program and shared by all local programs across the country.
- Contributing behavior and other factors are the root causes taken from your problem tree or fishbone analysis
- Indicators are your measures of success. More indicators are in Annex C. Targets are what you want to achieve in the timeframe that you set. Indicators and targets are the same as your SMART objectives.
- Important assumptions describe the environment or situation that, if it changes, may affect the achievement of your objectives.

3a: Program Matrix (blank)

Narrative	Indicators and Targets	Source of Data	Important Assumptions	Source of Funding
Vision (Goals)				
Health Status (Outcome) 1				
Strategy (Output) 1.1 **Major Activities**				
Strategy (Output) 1.2 **Major Activities**				
Strategy (Output) 1.3 **Major Activities**				
Health Status (Outcome) 2				
Strategy (Output) 2.1 **Major Activities**				
Output 2.2 **Major Activities**				

4: Results Chain (sample)

Major Activities	Outputs/ Strategies	Behavioral Outcomes	Health Status Outcome	Goals
Training for health service providers and teachers

Establishment of teen centres in schools | Adolescent-friendly health services will be available in schools, including provision of contraceptives with parent's consent | **Adolescents practice safer sex** | **Early pregnancies are reduced** | **Improved health status of adolescents**

Adolescents fully enjoy their right to health |
| Training of peer educators | Capacitating peer educators on behavior change and health education | | | |

4a: Results Chain (blank)

Major Activities	Outputs/ Strategies	Behavioral Outcomes	Health Status Outcome	Goals

5: Short- term Activity Plan (sample)

Indicators and Targets	Program Strategies	Activities	Resources Needed	Person Responsible	Timeframe	Budget Source
e.g. decrease age-specific fertility rate from 57 to 54 live births per 1,000 adolescent women in 5 years	Skilled health service providers	Develop capacities of health service providers on SRH-FP counseling Competency training Post-training mentoring Monitoring visit after 1 month Follow-up monitoring visit after 6 months Provide counseling room and educational materials in health centers	Trainers Venue Travel Materials	CHO Training Officer	1st quarter 2016	LGU budget (from GAD)

5a: Short- term Activity Plan (blank)

Indicators and Targets	Program Strategies	Activities	Resources Needed	Person Responsible	Timeframe	Budget Source

6: Checklist of Services and Providers (sample)

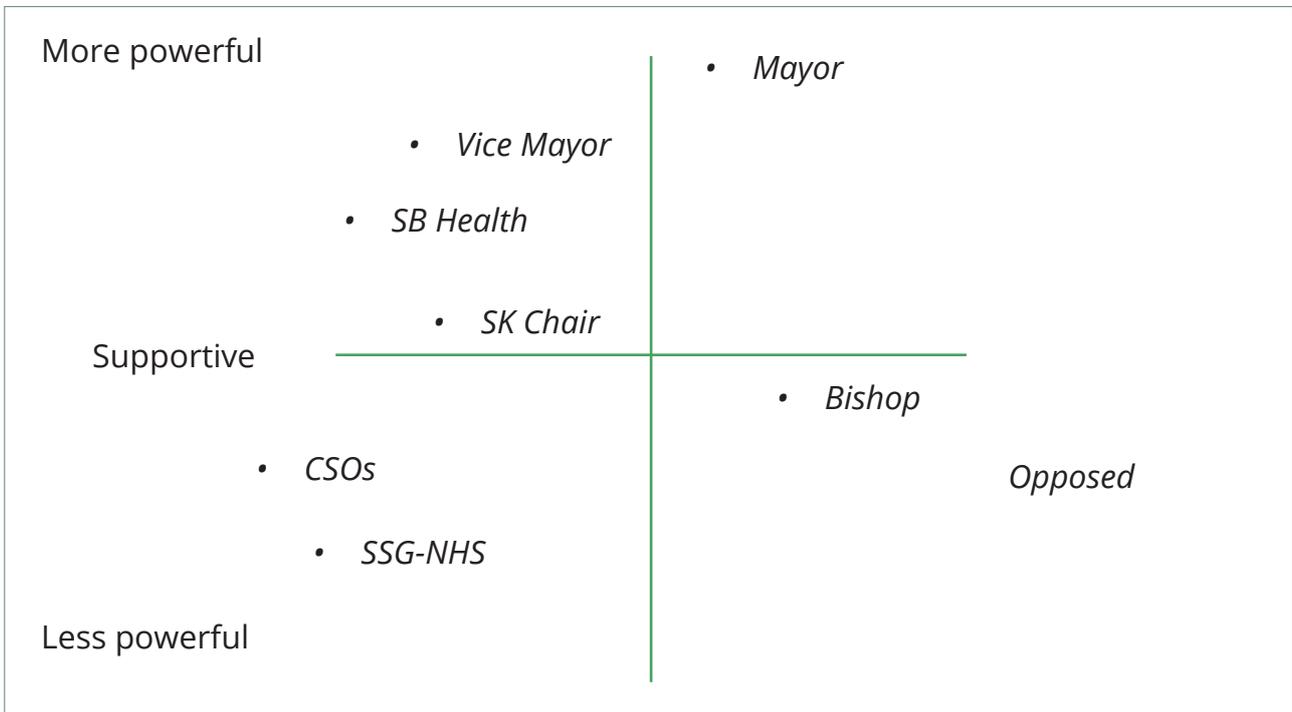| Services	Name of Service Providers				
	ABGH	CDH	KlinikaEF	Dr. GH	NGO, Inc.
General Health Assessment – History and Physical Exam					
Dental Assessment					
Psychosocial Risk Assessment and Management					
Nutrition Assessment & Counselling					
Micronutrient Supplementation					
Immunization					

6a: Checklist of Services and Providers (blank)

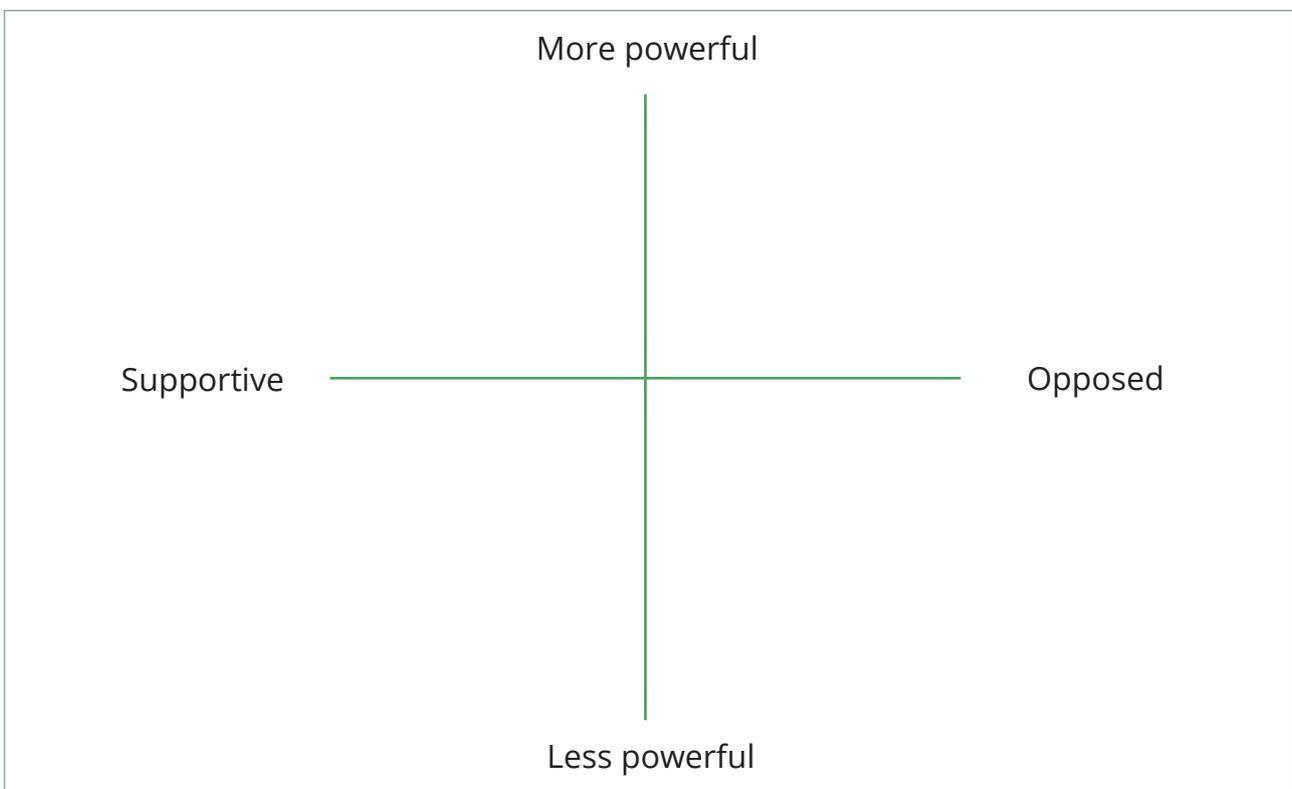| Services	Name of Service Providers								
Basic Services									
General Health Assessment – History and Physical Exam									
Dental Assessment									
Psychosocial Risk Assessment and Management									
Nutrition Assessment & Counselling									
Micronutrient Supplementation									
Immunization									
Basic Diagnostic Tests									
Reproductive Health Assessment and Counselling									
Fertility awareness, menstrual health issues, sexual and reproductive health counselling including contraceptive counselling									
Pap smear and pelvic exam if sexually active									
Adolescent male reproductive health issues									
Gender issues (VAWC Desk)									
Voluntary Counselling and Testing for STIs and HIV									
Risk Assessment (HEADSS)									

Services	Name of Service Providers								
Prevention of Adolescent Pregnancy Health education sessions Counselling									
Prenatal									
History and Physical Examination									
Immunization – Tetanus toxoid									
Micronutrient supplementation with iron, folate									
Psychosocial risk assessment									
Laboratory – CBC, blood typing (if not available, refer), pregnancy test, urinalysis									
Pregnancy counselling									
Nutrition counselling									
Birth plan including exclusive breastfeeding counselling									
Family planning counselling									
HBsAg test for pregnant mothers									
Natal (Birthing Homes)									
Safe delivery by skilled health worker at a mother-and baby friendly health facility									
Essential Newborn Care									

Services	Name of Service Providers								
Protocol									
Newborn package:, Vitamin K, Hepatitis B – birth dose, BCG, eye prophylaxis, Newborn Screening									
Postnatal									
Micronutrient Iron supplementation									
Counselling services: Family planning, Nutrition counselling, Exclusive Breastfeeding, Parenting									
Provision of FP services and commodities (with parental consent)									
Sexually Transmitted Infections/HIV Packages									
STI and HIV Risk Assessment									
Diagnostics: Gram Stain, RPR, C/S, HIV Counselling and or Testing									
Risk Reduction Counselling									
Voluntary Counselling and Testing for HIV/STIs									
Health Education									
Conduct of Adolescent Health sessions among in-school adolescents									
Conduct of Adolescent Health sessions among out-of-school adolescents									
Conduct of Parent Education sessions among parents of adolescents									
Other Services									

7: Stakeholders Analysis (sample)

More powerful

- Mayor

- Vice Mayor

- SB Health

- SK Chair

Supportive

- Bishop

- CSOs

Opposed

- SSG-NHS

Less powerful

7a: Stakeholders Analysis (blank)

More powerful

Supportive

Opposed

Less powerful

8: Information on Health Providers (sample)

Province:
City/ Municipality:

Name of Service Provider	Address & Phone No.	Services Offered	Clientele	PhilHealth Accreditation Status	Type (public/ private)	Clinic Hours/ Schedule	Cost of Services	Contact Person
e.g. Batasan Social Hygiene Clinic	#1 IBP Road cor Commonwealth Ave. Bgy. Batasan Hills, QC Tel. 1234567	VD VCT RPR wet mount KOH	MSM, Female Sex workers registered or freelancer, MSW	PCB 1 & 2	Public	8am-4pm	65 for establishment fee	Dr. Juan dela Cruz 0917-1234567
Klinika Bernardo	Ermin Garcia St. Brgy. Pinagkaisahan cr. Edsa Cubao Tel. 8901234	VCT, Basic Laboratories for PLHIV/ clients (CBC Urinalysis sputum RPR,	All	PCB 1 & 2	Public	3-11pm	None	Dr. Juana San Juan 0918-0987654

8a: Information on Health Providers (blank)

Province:
City/ Municipality:

Name of Service Provider	Address & Phone No.	Services Offered	Clientele	PhilHealth Accreditation Status	Type (public/ private)	Clinic Hours/ Schedule	Cost of Services	Contact Person

9: Partner Mapping (sample)

Partner/ Ally	Description	Value of Cooperation	Tactics for Collaboration
e.g. NGO, Inc.	*Organizes youth groups*	*Good relationships at the community level* *Would benefit from involvement at the city level*	*Start with information sharing* *Possible member of advocacy network to push for a local ordinance on AHDP*

9a: Partner Mapping (blank)

Partner/ Ally	Description	Value of Cooperation	Tactics for Collaboration

10: Advocacy Plan (sample)

Policy Change Objective	Target Policymakers	Channels to Reach Policymakers	Milestones
e.g. Enact a municipal ordinance on the Service Delivery Network for adolescents	Sangguniang Bayan (SB) Mayor	Presentation during regular SB meeting Lobbying (one-on-one) Petition signing	Developed advocacy plan with SDN members Got agreement from Mayor to proceed Presented draft of proposed ordinance to city council Passage of ordinance
e.g. Enforce the curfew for minors	Barangay Chairman Barangay Tanods	Meeting with Barangay Chairman and Tanods	

10: Advocacy Plan (blank)

Policy Change Objective	Target Policymakers	Channels to Reach Policymakers	Milestones

Annex L

AHDP Technical Working Group Department Order

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

June 20, 2017

DEPARTMENT PERSONNEL ORDER
No. 2017- 2796

> **SUBJECT:** <u>Creation of the Technical Working Group for Adolescent Health and Development</u>

I. BACKGROUND AND RATIONALE

Twenty-one percent or roughly 20 million of the total population of the Philippines is compromised of adolescents, aged 10-19 years (NSO, 2010). Adolescent face many threats to their health and well – being. Drowning and transport accidents are among the top five causes of death among the 10 – 14 and 15 – 19 age groups (DOH, 2005). A study in 2013 (Youth and Adolescent Fertility Survey 4) showed that 1 in 3 adolescents, aged 15 – 19 years old, reported having early sexual encounters and that 78 percent of the first sexual debuts are unprotected. Another feature that can be observed is the steadily increasing rate of adolescent pregnancy, the same studied presented that from 6.3 percent in 2002, the percentage of girls aged 15-19 years old who are mothers or pregnant for the first time rose to 13.6 percent. The 2015 Global School-based Student Health Survey (GSHS) gathered that 16.8% of students, ages 13 – 17 have attempted suicide one or more times during the 12 months before the survey was conducted. On the same survey, 15.8% of students ages 13 – 17 are currently using any tobacco products. The first Philippine National Baseline on Violence against Children stated that the prevalence of sexual violence amongst adolescents from 13 to 17 years old is 17%. Also, the 2015 Integrated HIV Behavioral and Serologic Surveillance (IHBSS 2015) showed that 62% of estimated new HIV infections come from Filipinos who are 18 to 24 years old. To add, 1,163 adolescents were diagnosed with HIV in the country from January 2010 to October 2016 based on the HIV and AIDS and ART Registry in the Philippines (HARP) October 2016.

The DOH has determined that it is important to strengthen the focus on the second decade of life – adolescents – a critically important period in person's life. The agency, through the Family Health Office, issued Administrative Order No. 2013-0013 (National Policy and Strategic Framework on Adolescent Health and Development) mandated the creation of the National Adolescent Health and Development Program (AHDP) Technical Working Group, to support implementation of adolescent health and development programs, an essential component to achieve the national strategy of the Philippine Health Agenda – "All for Health Towards Health for All" and the Sustainable Development Goals. The technical working group will ensure operationalization of the program, and provide assistance in the formulation and implementation of relevant policies, guidelines, appropriate actions, and recommendations arising from various issues and concern.

II. OBJECTIVES

1. To ensure operationalization of the Adolescent Health and Development Program
2. To provide assistance in the formulation and implementation of relevant policies, guidelines, appropriate actions, and recommendations arising from various issues and concerns.

III. COMPOSITION

The DOH shall act as the lead convener agency that will focus on the health concerns of the adolescents, and the National Youth Commission (NYC) will be the co-lead convener that will focus on the non-health concerns of adolescents, both of them will ensure the implementation and monitoring of this Order.

DOH Adolescent Health and Development Program (AHDP) shall also convene an Internal Coordinating Body within the department, which will be composed of different program managers that handle adolescents.

IV. MEMBERSHIP

DEPARTMENT OF HEALTH INTERNAL COORDINATING BODY
1. Adolescent Health and Development Program
2. Safe Motherhood Program
3. Nutrition Program
4. Vaccine Preventable Disease
5. Family Planning
6. Women and Children Protection Program
7. Injury Program
8. Oral Health Program
9. National STI and HIV Prevention and Control Program
10. National Mental Health Program
11. Lifestyle Related Diseases Division: Harmful Use of Alcohol
12. Lifestyle Related Diseases Division: Tobacco Control
13. Dangerous Drugs Abuse Prevention and Treatment Program
14. Health Policy Development and Planning Bureau
15. Health Promotion and Communication Service
16. Health Human Resource Development Bureau
17. Epidemiology Bureau

TECHNICAL WORKING GROUP
1. Department of Health – Family Health Office
2. National Youth Commission
3. Commission on Higher Education
4. Commission on Population
5. Council for the Welfare of the Children

6. Department of Education – School Health Division
7. Department of Education – Curriculum Development Division
8. Department of Social Welfare and Development
9. Department of Interior and Local Government
10. Linangan ng Kababaihan (Likhaan)
11. The Family Planning Organization of the Philippines
12. Technical Education and Skills Development Authority
13. WomanHealth Philippines
14. Save the Children
15. ACT! 2015 Alliance
16. Youth Peer Education Network
17. Society of the Adolescent Medicine in the Philippines Inc.
18. Micronutrient Initiatives

The AHDP Technical Working Group may invite representatives from the government, non-government, local government units, official development assistance partners, academe, youth-led organizations, councils, specializations, and other groups as resource persons and can provide inputs on consultations and meetings, as the need arises. The following but not limited to, are part of technical resource group:

1. Child Protection Network
2. National Nutrition Council (NNC)
3. Philippine National AIDS Council (PNAC)
4. Philippine Society of Adolescent Medicine Specialist (PSAMS)
5. United Nations for Children's Fund (UNICEF)
6. United Nations Population Fund (UNFPA)
7. United Nations Programme for HIV and AIDS (UNAIDS)
8. United States Agency for International Development (USAID)
9. World Health Organization (WHO)

V. FUNCTIONS OF THE DOH INTERNAL COORDINATING BODY

1. Provide technical inputs to the Adolescent Health and Development Program
2. Facilitate the collaboration of other programs that will affect the Adolescent Health

VI. FUNCTIONS OF THE TECHNICAL WORKING GROUP

Provide evidence-based technical advice and support on the following AHDP program areas:

1. Policies, guidelines, and strategies
2. Capacity – building
3. Service Delivery Network (SDN)
4. Advocacy, Communication, and Social Mobilization
5. Research
6. Monitoring and Evaluation Framework
7. Financing

Department of Health and National Youth Commission shall perform the following secretariat functions for the AHDP Technical Working Group:

1. Provide administrative support during activities and meetings of the TWG members
2. Document and disseminate the proceedings of the activities and meetings of the TWG members

The DOH Internal Coordinating Body and TWG shall convene immediately from the issuance of this Order and shall have a regular meeting at least once every quarter or as may be determined by the groups, and strict presence of representatives must be followed.

VII. FUNDING SUPPORT

Under this Order, all expenses that will be incurred in the conduct of the meetings and activities of the TWG shall be charged against the funds allotted for Family Health Office subject to the usual accounting and auditing rules and regulations.

VIII. EFFECTIVITY

This order shall take effect immediately.

PAULYN JEAN B. ROSELL – UBIAL, MD, MPH, CESO II
Secretary of Health

Annex M

Focus Group Discussion Guide

A Focus Group Discussion (FGD) is a qualitative research method used in conjunction with service statistics and surveys. This does not replace service statistics and surveys which are quantitative methods. You will still need to show the prevalence or severity of adolescent health issues. Rather, quantitative and qualitative data complement each other. Quantitative data describe the breadth or severity of the issue while qualitative data describes the issue in depth. Together, they provide a comprehensive view of adolescent health issues.

FGD tips:

- Do conduct FGDs in groups of 6-8 persons.
- Do keep the groups homogenous, i.e. participants in each group should have the same characteristics – same age, gender, socioeconomic class. Have separate groups for 10-14 and 15-19 year olds and for boys, girls, lesbians, gays, bisexual, and transgender adolescents. In-school adolescents should be in a different group from out-of-school youth.
- Do have a note-taker. It helps to have someone take notes so you can focus on moderating the discussion.
- Do use open-ended rather than yes or no questions. If you use yes or no questions, ask them to elaborate on their answer by asking, "What makes you say that?" or "What are the possible reasons for that?"
- Do encourage every participant to air their thoughts and opinions. If a participant hasn't been able to speak, you can ask them to comment on what someone else said. You can ask, "What do you think of what ____ said?"
- Do pause after each question to give the participants ample time to think about what they want to say.
- Do watch for body language and facial expressions that indicate they have something to say.
- Don't force someone to talk if she/he doesn't want to.
- Don't go around the group and ask each participant to give an answer. Let them volunteer.
- Don't correct any misconceptions or misinformation during the discussion. Do that at the end of the FGD.
- Do translate this guide into the local language prior to conducting the FGD.

For adolescents

Introduction

Good morning/afternoon. I'm _____ from the _____ (agency/organization).
We are _____ (describe your agency/organization).

I would like to talk to you about adolescents. Adolescents are persons 10-19 years old and are at a crucial stage in their development from a child to an adult. We will discuss various issues and concerns of adolescents like you. Please answer truthfully and explain your answers. There are no right or wrong answers. You are the experts here. We value all your opinions and we need to understand your point of view in order to improve the services we offer.

(Introduce your note taker) This is my colleague _____. She/he will be taking down notes while we discuss. Everything we talk about is confidential and you will not be named in any report or document that we will release to the public.

(If using a recording device) Is it okay if we record our discussion? We want to make sure we don't miss any of your points or opinions. Only I and my colleague here will be able to hear this recording.

Discussion Guide

1. What comes to mind when someone says "adolescent"?
2. What do adolescents like to do?
3. Describe a typical day in the life of an adolescent like you.
4. What health issues/ problems do adolescents face?

For every health issue, ask the following:
a. What are the causes of this issue?
b. What do adolescents do that put them at risk for this issue/problem?
c. What do you think should be done to protect adolescents from these risks?

5. On early pregnancy:
a. Why do you think adolescents get pregnant?
b. Why do you think adolescents engage in sex?
c. What would prevent adolescents from engaging in unprotected sex?

6. Are there other issues that we haven't discussed?

Closing

At this point the moderator should:

- Summarize main points. Read the list of health issues you discussed and any other points that figured prominently in your discussion.
- Ask the participants if there was anything they said that they would like to retract.
- Ask the participants if they have any questions. Say that it is now their turn to ask you questions.
- This is also the time to correct any misconceptions or misinformation that the participants said during the discussion.
- Discuss what happens next. For example, the results of the FGD will be used to improve services and the delivery of information to adolescents. Inform participants of any followup, upcoming activities, or services that they can avail of.
- Thank the participants for their time and participation.

For parents

Introduction

Good morning/afternoon. I'm _____ from the _____ (agency/organization). We are _____ (describe your agency/organization).

I would like to talk to you about adolescents. Adolescents are persons 10-19 years old and are at a crucial stage in their development from a child to an adult. We will discuss various issues and concerns of parents like you who have adolescent children. Please answer truthfully and explain your answers. There are no right or wrong answers. You are the experts here. We value all your opinions and we need to understand your point of view in order to improve the services we offer to your adolescents.

(Introduce your note taker) This is my colleague _____. She/he will be taking down notes while we discuss. Everything we talk about is confidential and you will not be named in any report or document that we will release to the public.

(If using a recording device) Is it okay if we record our discussion? We want to make sure we don't miss any of your points or opinions. Only my colleague here and I will be able to hear this recording.

Discussion Guide

1. What comes to mind when someone says "adolescent"?
2. What have you learned as a parent of an adolescent?
3. What concerns or challenges do you face as parents of adolescents?
4. What form of support do you need to help you become better parents of adolescents?
5. Who else helps you take care of your adolescent? What are her/his role in the life of your adolescent?
6. Are there other issues that we haven't discussed?

Closing

At this point the moderator should:

*   Summarize main points. Read the list of health issues you discussed and any other points that figured prominently in your discussion.
*   Ask the participants if there was anything they said that they would like to retract.
*   Ask the participants if they have any questions. Say that it is now their turn to ask you questions.
*   This is also the time to correct any misconceptions or misinformation that the participants said during the discussion.
*   Discuss what happens next. For example, the results of the FGD will be used to improve services and the delivery of information to adolescents. Inform participants of any followup, upcoming activities, or services that they can avail of.
*   Thank the participants for their time and participation.

Annex N

Sample Agenda for an AHDP Strategic Planning Workshop

Workshop to Develop a Local Adolescent Health and Development Program
Date
Venue
Rationale

The Philippine Department of Health (DOH) issued Administrative Order N. 2013-0013 (National Policy and Strategic Framework on Adolescent Health and Development) on 21 March 2013. The actual implementation of the AO at the local level has remained a challenge due to different interpretations and limited capacity of staff at health facilities including many hospitals, the Rural/City Health Units (R/CHUs), and Barangay Health Stations (BHS). Thus, a manual of operations was developed with support from the World Health Organization (WHO)-Philippine Country Office. This manual is intended for adolescent health and development program officers, focal persons, and clinic managers in government, private, and NGO health facilities. It will enable local governments to design their own adolescent health and development program.

Participants

An estimated 20 persons will participate in this workshop. They are expected to have a basic understanding of adolescent-friendly health services and issues facing adolescents in their city.

Participants from each city may include the following:

1. City/Municipal Health Officer
2. Adolescent health program officer/ point person (Facilitator)
3. Social worker
4. School nurse or clinic teacher
5. Community-based organization or non-government partner
6. City Planning Officer or City Councilor
7. Adolescent (10-19 year old) peer educators*
8. Regional Office for Health point person for adolescent health and development
9. POPCOM Regional Office

* Strive to have at least 20% of participants should be adolescents who have participated in a planning session and are familiar with the strategic planning process.

Objective

By the end of the workshop, participants will have a localized Adolescent Health and Development Program for their province, city or municipality, containing

1. Situational analysis
2. Health and Behavioral Outcomes
3. Outputs/ Strategies
4. Main Activities
5. Indicators for Monitoring and Evaluation

Agenda

DAY 1		
8:30-10:00 am	Briefing of adolescent participants	Ensure that adolescent participants understand the strategic planning process and know their role in the workshop. They should be able to ask questions and express their views prior to the start of the workshop with adults.
10:00-10:15	Break	
10:15-11:00	Opening	
	Introductions	
	Expectations	
	Objectives of training	
	House Rules	
11:00 -12:00	A.O. 2013-0013	See pages 10-13
	Overview of the Manual (Objectives, Target Users, Development Process)	
12:00-1:00 pm	Lunch	
1:00-2:30	Biological and Psychosocial Changes in Adolescence	Lumalaki, Tumutubo, Nagkakaroon (See pages 19-20 and Annex R)
	Health Situation of Filipino Adolescents	Ilan ang ... (See page 24-26 and Annex S)
2:30-3:30	AHD Program Development Cycle	Arrange the cards (See pages 34-36 and Annex S)
3:30-3:45	Break	
3:45-4:00	Synthesis and Evaluation of Day 1	Ask: What do you feel at the end of the day? What are your new learnings? What do you want to see improve? Other comments?

DAY 2		
9:00-9:15	Recap of Day 1	Ask: What did you see? hear? feel?
9:15-10:00	Step 1: Organize a working group	(See pages 48-53)
	Step 2: Analyze the situation	(See pages 54-56)
	Step 3: Define health status & behavioral objectives	(See pages 57-63 and Annex B-Worksheets 1 and 2
10:00-10:15	Break	
10:15-12:00	Group work: Steps 1 to 3 Presentation of group outputs for Steps 1 to 3	
12:00-1:00 pm	Lunch	
1:00-2:00	Step 4: Identify program Strategies	(See pages 64-71 and Annex B-Worksheets 2 and 3)
2:00-3:30	Group work: Step 4	
3:30-3:45	Break	
3:45-4:45	Presentation of group outputs for Step 4	
4:45-5:00	Synthesis and Evaluation of Day 2	Ask: What do you feel at the end of the day? What are your new learnings? What
		do you want to see improve? Other comments?

DAY 3		
9:00-9:15	Recap of Day 2	Ask: What did you see? hear? feel?
9:15-10:00	Policy Advocacy	(See pages 129-131)
10:00-10:15	Break	
10:15-11:00	Step 5: Develop an activity plan, including an advocacy plan Step 6: Implement and monitor Step 7: Assess and evaluate	Using metacards, adolescents list what activities they want to happen. Adults translate into objectives and indicators in the logframe, but should also validate with adolescents that these are what they had in mind.
11:00-12:00	Group work: Steps 5-7	(See pages 72-80 and Annex B-Worksheets 4 to 10)
12:00-1:00	Lunch	
1:00-2:00	Continuation of group work	
2:00-3:00	Presentation of group outputs for Steps 5-7	
3:00-3:15	Break	
3:15-3:45	Immediate next steps and assignments for filling-in gaps in program plan	
3:45-4:00	Workshop Evaluation Closing	

Annex O

Additional Resources

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Annex P

Additional Resources

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