MANUAL OF OPERATIONS

On Adolescent Health and Development Program
For Program Managers

World Health Organization
Western Pacific Region
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. Issues such as early pregnancy, sexually transmitted infections, including HIV and AIDS, substance use disorders, violence, and mental illness threaten to derail this vision. Thus, we need to encourage protective behaviors and give them the tools to lower risky behaviors.

The Department of Health responds to these concerns by ensuring access to quality health care and services in an adolescent-friendly environment. RA 10354, the Responsible Parenthood and Reproductive Health Act of 2012, DOH AO 2013-0013, the National Policy and Strategic Framework on Adolescent Health and Development, and other policies demonstrates the government's commitment to the health of Filipino adolescents.

This manual of operations is one of the tools developed for the Adolescent Health and Development Program. We have also produced the Standards for Adolescent-Friendly Health Services, the Competency Training on Adolescent Health for Health Service Workers, Adolescent Job Aid, and the Guidelines for the Implementation of Adolescent Immunization.

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.

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

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-HAI): 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-HAI 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.

Dr. Gundo Aurel Weiler
WHO Representative in the Philippines
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- Department of Education (DepEd)
- Department of Social Welfare and Development (DSWD)
- Department of Interior and Local Government (DILG)
- World Health Organization

and development partners,
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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
DCCPB   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
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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.

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.
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.

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.

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.

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

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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, but 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

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 adolescents.

Specifically, this section includes the following subsections:

A. Managing the Adolescent Health and Development Program

B. Ensuring Privacy

C. Strengthening Confidentiality

D. Enhancing Capacities of the Health Care Providers

Sensitizing Health Care Providers or Programmers
Training Health Care Providers or Programmers

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HEEADSS Form

F. Health Promotion and Behaviour Change

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b. Different Materials or Resources from Institutions

G. Adopting the Program Development and Management Approach

Step 1: Organize a Working Group
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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 subsections:

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

Scope and Limitations
AHDP M&E Framework
Program Indicators
M&E Tools

Section 8
Annexes, Resources, and References

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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

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**
  - 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

- **Widening gap between biological maturity and social transition to adulthood**
  - 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

- **Balance between protection and autonomy**
  - 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 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
- Adolescents survivors of abuse and exploitation

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
- 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)
- Adolescents (Children) in conflict with the law
- 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)

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.

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.
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.

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 once 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.
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<0.05).

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

![Health assessment chart](image)

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

![Births chart](image)

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 of 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).

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

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

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%.
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.

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.
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 fulfill 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.

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.
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.

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
- 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.

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

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 as a human right. 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 fulfill their rights and responsibilities to provide direction and guidance to their adolescent children in the exercise 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 herself/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.

Universal Health Coverage (UHC)

AHD 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.

International Conference on Population and Development (ICPD, 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.”

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 forms of abuse, neglect, cruelty exploitation and discrimination and other conditions, prejudicial to 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 consents 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 teenagelbehaviour; 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;
- Developing 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.
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.
- 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. 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 (AHRP), 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 multisectoral team that will work on the planning and implementation of your AHRP.

**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.
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**

<table>
<thead>
<tr>
<th>Inputs</th>
<th>Major Activities</th>
<th>Outputs/Strategies</th>
<th>Outcomes</th>
<th>Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resources – human resource, funds, technical assistance and other types of resources are mobilized in activities to produce specific outputs</td>
<td>Actions taken or work performed through which inputs, such as funds, technical assistance and other types of resources are mobilized to produce specific outputs.</td>
<td>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.</td>
<td>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.</td>
<td>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.</td>
</tr>
</tbody>
</table>

**Results Chain Example**

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

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.

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**

<table>
<thead>
<tr>
<th>Step</th>
<th>How do you involve?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Organize a team</td>
<td>Include members of student government, school organizations, out-of-school youth, gangs, and other adolescent-led groups</td>
</tr>
<tr>
<td>2. Analyze the situation</td>
<td>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</td>
</tr>
<tr>
<td>3. Define health status &amp; behavioral objectives</td>
<td>Incorporate their views in the criteria for selection of priority outcomes</td>
</tr>
<tr>
<td>4. Identify program strategies</td>
<td>Ask them to participate in meetings to formulate program strategies and plans</td>
</tr>
<tr>
<td>5. Develop an activity plan</td>
<td>Ask them to participate in meetings to formulate program strategies and plans</td>
</tr>
<tr>
<td>6. Implement and monitor</td>
<td>Ask them for their views on how the program is working so far</td>
</tr>
<tr>
<td>7. Assess and evaluate</td>
<td>Ask them for their views on the impact and effectiveness of the program</td>
</tr>
</tbody>
</table>

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.
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 AHDP
  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
  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.

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.

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)
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 your 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 cafés, 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.
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 risks 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. 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.

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 anemia. 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

Analysis of contributing behaviours and other factors

Now that you have the what of your Health Status Outcomes, it is time to analyze 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**
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.

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.

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 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.

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)?

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.

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 have to do fundraising to cover these costs.

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.
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.
Section 4

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 of 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>
<thead>
<tr>
<th>No.</th>
<th>INSTITUTIONAL COMMITMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Are the senior management or heads of the institutions sensitized about adolescent health and development as a public health problem?</td>
</tr>
<tr>
<td>2</td>
<td>Have they voiced their support for the effort to address the adolescent health program as a public health problem?</td>
</tr>
<tr>
<td>3</td>
<td>Has the agency made an explicit commitment to adolescent friendly health care services, ideally in writing?</td>
</tr>
<tr>
<td>4</td>
<td>Have you identified individuals in your institution or health centre that will lead or handle the adolescent health and development program?</td>
</tr>
<tr>
<td>5</td>
<td>Do you have funds allotted for the implementation of the AHDP?</td>
</tr>
<tr>
<td><strong>REFERRAL NETWORKS AND PARTNERSHIPS</strong></td>
<td></td>
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<tr>
<td>6</td>
<td>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?</td>
</tr>
<tr>
<td>7</td>
<td>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?</td>
</tr>
<tr>
<td>8</td>
<td>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?</td>
</tr>
<tr>
<td>8</td>
<td>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?</td>
</tr>
<tr>
<td>9</td>
<td>Do these directories include resources for special groups such as indigenous populations, adolescents with disabilities, adolescent key population, adolescent living with HIV etc?</td>
</tr>
<tr>
<td>10</td>
<td>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)?</td>
</tr>
<tr>
<td>11</td>
<td>Has the health centre gathered feedback from providers about the directories?</td>
</tr>
<tr>
<td>12</td>
<td>Has the health centre developed a way (either formal or informal) to monitor the quality of referral services in the community?</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th><strong>LOCAL SUPPORT OR TECHNICAL ASSISTANCE</strong></th>
<th></th>
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<tbody>
<tr>
<td>13</td>
<td>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?</td>
</tr>
<tr>
<td>14</td>
<td>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?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>PRIVACY AND CONFIDENTIALITY</strong></th>
<th></th>
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<tbody>
<tr>
<td>15</td>
<td>Are consultation rooms built in such a way that clients cannot be heard or seen from outside?</td>
</tr>
<tr>
<td>16</td>
<td>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?</td>
</tr>
<tr>
<td>17</td>
<td>Does the institution or health centre have written policies about confidentiality that explain the following:</td>
</tr>
<tr>
<td></td>
<td>• How to ensure that health centre records are kept in a secure place?</td>
</tr>
<tr>
<td>18</td>
<td>Does the institution or health centre have written policies about confidentiality that explain the following:</td>
</tr>
<tr>
<td></td>
<td>• Which staff members have access to medical records?</td>
</tr>
<tr>
<td>19</td>
<td>Does the institution or health centre have written policies about confidentiality that explain the following:</td>
</tr>
<tr>
<td></td>
<td>• 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.)?</td>
</tr>
<tr>
<td>20</td>
<td>Does the institution or health centre have written policies about confidentiality that explain the following:</td>
</tr>
<tr>
<td></td>
<td>• 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?</td>
</tr>
<tr>
<td>21</td>
<td>Does the institution or health centre have written policies about confidentiality that explain the following:</td>
</tr>
<tr>
<td></td>
<td>• Whether and when health care providers should report cases of physical or sexual violence to the authorities?</td>
</tr>
<tr>
<td>22</td>
<td>If any reporting requirements do exist, what process should providers follow for obtaining a client's consent? When the client is minor.</td>
</tr>
<tr>
<td>23</td>
<td>Have all staff in the institution or health centre participated in sensitization workshops that explore adolescent health and development as a public health problem?</td>
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<tr>
<td>24</td>
<td>Have all staff who have direct contact with clients received in-depth trainings about:</td>
</tr>
<tr>
<td></td>
<td>• Adolescent Job Aid?</td>
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<td></td>
<td>• ADEPT?</td>
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<tr>
<td></td>
<td>• HEEADSSS?</td>
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<tr>
<td></td>
<td>• Gender-based violence?</td>
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<tr>
<td></td>
<td>• HIV and AIDS?</td>
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<tr>
<td></td>
<td>• Adolescent Friendly Health Services?</td>
</tr>
<tr>
<td>25</td>
<td>Is there a mechanism to sensitize and train new staff members soon after they are hired?</td>
</tr>
<tr>
<td>26</td>
<td>Is there a mechanism to provide ongoing and repeated training concerning both general and specific issues related to adolescent health and development?</td>
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<tr>
<td>27</td>
<td>Is there a mechanism for distributing written, educational information on adolescent health (bulletins, memos, etc.) among the health staff on a regular basis?</td>
</tr>
<tr>
<td>28</td>
<td>Have health care providers received training about legal issues related to adolescent health, including reporting requirements (if any)?</td>
</tr>
<tr>
<td>29</td>
<td>Is there a mechanism to provide emotional support to staff on a regular basis?</td>
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</tbody>
</table>

**HEALTH PROMOTION AND COMMUNICATION**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>23</td>
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**PROTOCOLS FOR CARING FOR ADOLESCENTS WITH SPECIAL NEEDS**

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<table>
<thead>
<tr>
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<tbody>
<tr>
<td>35</td>
<td>Do all clinics or health centres have written protocols for caring for adolescents who experience the following:</td>
</tr>
<tr>
<td></td>
<td>• Physical violence by an intimate partner or another family member?</td>
</tr>
<tr>
<td></td>
<td>Adolescents living with HIV?</td>
</tr>
<tr>
<td>36</td>
<td>Internal and external referral services?</td>
</tr>
<tr>
<td>37</td>
<td>Reporting requirements (if any)?</td>
</tr>
</tbody>
</table>
### Screening of Adolescents Using HEEADSSS Assessment

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do all health centres have a written protocol explaining the tools in conducting screening for adolescents, when and how?</td>
<td></td>
</tr>
<tr>
<td>Do these protocols address the following: Privacy and confidentiality?</td>
<td></td>
</tr>
<tr>
<td>Do you have schedules on when to screen new clients?</td>
<td></td>
</tr>
<tr>
<td>Do you have schedules on when to screen returning clients?</td>
<td></td>
</tr>
<tr>
<td>Internal and external referral services?</td>
<td></td>
</tr>
<tr>
<td>Have all health care providers been trained to follow the assessment tool?</td>
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</tbody>
</table>

### Documenting Information Related to Screening

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is there a system for documenting whether a client has been asked screening questions?</td>
<td></td>
</tr>
<tr>
<td>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)?</td>
<td></td>
</tr>
<tr>
<td>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)?</td>
<td></td>
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</tbody>
</table>

### Follow-through on Referrals and Counter-referrals

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you have referral forms?</td>
<td></td>
</tr>
<tr>
<td>Is there a mechanism to verify if a client went to referral services outside the health centre?</td>
<td></td>
</tr>
<tr>
<td>Do you follow up to your clients even right after you referred them already?</td>
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</tbody>
</table>

### Monitoring and Evaluation

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has the institution or health centre made an effort to verify the quality of services provided at external referral services?</td>
<td></td>
</tr>
<tr>
<td>Has the institution gathered baseline information on health care providers' knowledge, attitudes, and practices?</td>
<td></td>
</tr>
<tr>
<td>Has the health centre staff faithfully document all the services provided in the monitoring forms?</td>
<td></td>
</tr>
<tr>
<td>Has the institution gathered clients' perspectives on the health service response to adolescent friendliness of the facility?</td>
<td></td>
</tr>
<tr>
<td>Has the institution monitored the quality of care on an ongoing basis? Do you gather client's satisfaction survey within the health centre?</td>
<td></td>
</tr>
<tr>
<td>Has the institution measured changes in health care providers' knowledge, attitudes, and practices over time?</td>
<td></td>
</tr>
</tbody>
</table>
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)

<table>
<thead>
<tr>
<th>Adolescents affected by gender-based violence</th>
<th>What can happen in a clinic that lacks privacy and confidentiality</th>
<th>Potential consequences for adolescents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adolescents who have experience violence in the past</td>
<td>Adolescents may not feel safe enough to disclose past experiences of violence to health care providers</td>
<td>Adolescents may miss an opportunity to seek help</td>
</tr>
<tr>
<td>Adolescents currently living in a violent situation</td>
<td>A violent family member may find out that a woman has told a health care provider about the violence</td>
<td>Adolescents may receive inappropriate care because providers misinterpret or misdiagnose their health status.</td>
</tr>
<tr>
<td>Adolescents whose partner or family members have the potential to react with violence</td>
<td>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</td>
<td>A partner of family member may react with violence after learning the confidential information revealed at the health center.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Key concerns regarding Privacy</th>
<th>Challenges</th>
<th>Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do the clinics have enough private space?</td>
<td>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.</td>
<td>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 office, 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.</td>
</tr>
<tr>
<td>Can patients be seen or heard from outside consultation rooms?</td>
<td>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, health care providers would be able to strengthen the walls and doors of consultation rooms to ensure privacy.</td>
<td>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).)</td>
</tr>
<tr>
<td>Do staff members protect adolescents’ right to privacy in practice?</td>
<td>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.</td>
<td>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.)</td>
</tr>
<tr>
<td>Have staffs been trained to understand the importance of clients’ privacy?</td>
<td>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 organization.</td>
<td>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).</td>
</tr>
</tbody>
</table>

74 Manual of Operations on Adolescent Health and Development Program for Program Managers
Confidentiality is an essential component of quality care and patient rights in any healthcare 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 health workers without parents, family, or friends.

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. Protecting adolescents’ privacy may require that providers understand the potential risks, use their judgment about what information to disclose in front of family members, and find creative strategies to obtain consent and to respect adolescents’ preference for having a family member or friend present during the consultation.

Many adolescents want their parents, family members or friends to be present when they meet with a health worker, and 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. Those 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.

Treating violence and the potential for it should not be taken lightly. Violence can be a breeding ground for many problems of adolescents. 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 situations of early pregnancy, violence and HIV.

**4.3 Strengthening Confidentiality**

Confidentiality is an essential component of quality care and patient rights in any healthcare 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 health workers without parents, family, or friends.

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Many adolescents want their parents, family members or friends to be present when they meet with a health worker, and 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. Those 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.

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, but were not developed with adequate participation or feedback from providers. 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.

**Sample Recommendations in Strengthening Confidentiality**

(adapted and revised from IPPF/WHR Tools)

<table>
<thead>
<tr>
<th>Key concerns regarding confidentiality</th>
<th>Challenges</th>
<th>Recommendations</th>
</tr>
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<tbody>
<tr>
<td>Are medical records stored in a secure place?</td>
<td>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.</td>
<td>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.</td>
</tr>
<tr>
<td>Are clients’ medical records kept in a secure place that can be locked and is closely supervised?</td>
<td>Do the health centres have written policies about who is allowed to access client records?</td>
<td>Has the health centre raised staff awareness about the importance of guarding the confidentiality of medical records?</td>
</tr>
</tbody>
</table>
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 Health 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 a 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:

<table>
<thead>
<tr>
<th>MODULE</th>
<th>TITLE</th>
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<tbody>
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<td>Adolescent-Friendly Health Services</td>
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<td>2</td>
<td>HEADSSS Interview</td>
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<td>3A</td>
<td>Taking Sexual History</td>
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<td>3B</td>
<td>Positive Pregnancy Test</td>
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<td>4</td>
<td>Adolescent Sexuality</td>
</tr>
<tr>
<td>5</td>
<td>Alcohol, Tobacco and Other Drugs (Substance Use and Misuse)</td>
</tr>
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D. The HEADSSS Interview Tool

In the AJA Manual and ADEPT e-Learning Tool, you will find a concise version of the HEADSSS 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 HEADSSS assessment is a screening tool for conducting a comprehensive psychosocial history and health risk assessment with a young person. HEADSSS 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 HEADSSS assessment with a young person.

<table>
<thead>
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<th>ASSESSMENT AREA</th>
<th>QUESTIONS</th>
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</table>
E - Education / Employment

Explore how they look after themselves; eating and sleeping patterns:
Explore the context of substance use (if any) and risk taking behaviours:
Explore their knowledge, understanding, experience, sexual orientation and sexual practices - Look for risk taking behaviour/abuse:
Explore mental health problems and continuous monitoring:
Explore how they look after themselves; eating and sleeping patterns:
Explore risk of mental health problems, strategies for coping and available support:

F - Finances

S - Safety

A - Activities and Peer Partnerships

D - Drug Use/Cigarettes/Alcohol

S - Suicide/ Self Harm/ Depression/ Mood

S - Spirituality

Assessment Area

H - Home

Explore the social and interpersonal relationships, risk taking behaviour, as well as their attitudes about themselves:

E - Eating and Exercise

Explore exercise:

Questions

Partnerships and Peer Activities

Excercise

Employment

Education / Assessment Area

Are you involved in sports/hobbies/clubs, etc.?

What's your favourite music?

night?

What are some of the things you like about
taking care of yourself?

What do you get on with others your own age?

Do you have friends from outside your own cultural group/from the same cultural group?

What have you been in any romantic relationships or been dating anyone?

Who are your main friends (at school/out of school)?

It’s normal to feel anxious in certain situations - do you ever feel very anxious or stressed (e.g. in social situations)?

What do you know about contraception and protection against STIs?

Who are you closest to in your family?

Explore their knowledge, understanding, experience, sexual orientation and sexual practices - Look for risk taking behaviour/abuse:

who, or your family, argue about the most?

Any recent changes in education/employment?

S - Sexuality

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/drug/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 pay for the drugs/alcohol?

Do you have any problems as a result of your

Have you had any problems as a result of your

How do you pay for the drugs/alcohol?

Have you had any problems as a result of your

What effects does drug taking or smoking or alcohol,

who have on you? Has your use increased recently?

What sort of things do you (and your friends) do when you
take drugs/alcohol?

What do you usually eat for breakfast/lunch/dinner?

Have there been any recent changes in your weight?

Do you ever find yourself feeling really high energy
during the day, or even really sluggish?

Are there any fights at home? If so, what do you and/
or your family argue about the most?

Do you have friends from outside your own cultural group/from the same cultural group?

health and academic performance?

Do you like your body?

Who are you closest to in your family?

Any recent changes in education/employment?

Explore their knowledge, understanding, experience, sexual orientation and sexual practices - Look for risk taking behaviour/abuse:

Who are you closest to in your family?

Who can you talk to when you’re feeling down?

Do you ever feel that way?

Do you feel sad or down more than usual? How long

Who are your main friends (at school/out of school)?

Have you found yourself feeling really high energy
during the day, or even really sluggish?

Have you been in any romantic relationships or been dating anyone?

Who are your main friends (at school/out of school)?

What have you been in any romantic relationships or been dating anyone?

What prevented you from going ahead with it?

How do you try to harm/kill yourself?

Have you ever felt that way? Have you ever deliberately

hurting, or even killing themselves. Have you ever found yourself feeling really high energy
during the day, or even really sluggish?

Strategies for coping and available support:

Sometimes when people feel really down they feel like
trying to hurt, or even killing themselves. Have you ever
derately harmed or injured yourself cutting, burning or putting

yourself in unsafe situations - e.g. unsafe sex?

What prevented you from going ahead with it?

Who can you talk to when you’re feeling down?

Have you ever felt really anxious all

Are there any fights at home? If so, what do you and/
or your family argue about the most?

What do you get on with others your own age?

Do you have friends from outside your own cultural group/from the same cultural group?

Have you ever felt really anxious all

Are there any fights at home? If so, what do you and/
or your family argue about the most?

What are some of the things you like about
taking care of yourself?

What do you get on with others your own age?

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or your family argue about the most?
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 scientifically-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

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.
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.

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

- **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.

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 involvement 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.

**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.
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 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. See Annex: Best Practice section for an example.

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 described in Annex : Best Practice section.

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:

<table>
<thead>
<tr>
<th>Standard</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard 1</td>
<td>Adolescents’ health literacy. 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.</td>
</tr>
<tr>
<td>Standard 2</td>
<td>Community support. 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.</td>
</tr>
<tr>
<td>Standard 3</td>
<td>Appropriate package of services. 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.</td>
</tr>
<tr>
<td>Standard 4</td>
<td>Providers’ competencies. Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfill adolescents’ rights to information, privacy, confidentiality, non-discrimination, non-judgemental attitude and respect.</td>
</tr>
<tr>
<td>Standard 5</td>
<td>Facility characteristics. 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.</td>
</tr>
<tr>
<td>Standard 6</td>
<td>Equity and non-discrimination. 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.</td>
</tr>
<tr>
<td>Standard 7</td>
<td>Data and quality improvement. 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.</td>
</tr>
<tr>
<td>Standard 8</td>
<td>Adolescents’ participation. 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.</td>
</tr>
</tbody>
</table>
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 protected;
    - 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 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).

- **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 an IEC Plan;
    - There is a schedule of meetings 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 Advocacy Plan;
    - 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 Organization of the Philippines), a staff member is trained to help adolescent living with HIV plan ways to identify 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

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

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

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

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

<table>
<thead>
<tr>
<th>General Health Assessment - History and Physical Exam</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dental Assessment</td>
</tr>
<tr>
<td>Psychosocial Risk Assessment and Management</td>
</tr>
<tr>
<td>Nutrition Assessment &amp; Counselling</td>
</tr>
<tr>
<td>Micronutrient Supplementation</td>
</tr>
<tr>
<td>Immunization</td>
</tr>
<tr>
<td>Basic Diagnostic Tests</td>
</tr>
<tr>
<td>Reproductive Health Assessment and Counselling</td>
</tr>
<tr>
<td>Fertility awareness, menstrual health issues, sexual and reproductive health counselling including contraceptive counselling</td>
</tr>
<tr>
<td>Pap smear and pelvic exam if sexually active</td>
</tr>
<tr>
<td>Adolescent male reproductive health issues</td>
</tr>
<tr>
<td>Gender issues (VAWC Desk)</td>
</tr>
<tr>
<td>Voluntary Counselling and Testing for STIs and HIV</td>
</tr>
<tr>
<td>Risk Assessment (HEEADSSS)</td>
</tr>
<tr>
<td>Prevention of Adolescent Pregnancy</td>
</tr>
<tr>
<td>Health education sessions</td>
</tr>
<tr>
<td>Counselling</td>
</tr>
</tbody>
</table>

### 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
Section 6

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**

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 institutions 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.
**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.

**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:

- What is the 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?

Then ask more specific questions about the types of services available for adolescents, for example:

- 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**

<table>
<thead>
<tr>
<th>Full Name of the Office</th>
<th>Department of Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acronym</td>
<td>DOH</td>
</tr>
<tr>
<td>Type of Institution</td>
<td>Government / Public</td>
</tr>
<tr>
<td>Address</td>
<td>Tayuman, Manila</td>
</tr>
<tr>
<td>Telephone</td>
<td>911-11-11</td>
</tr>
<tr>
<td>Fax</td>
<td>922-22-22</td>
</tr>
<tr>
<td>Email</td>
<td><a href="mailto:dohahdp@gmail.com">dohahdp@gmail.com</a></td>
</tr>
<tr>
<td>Name of the Head and Position</td>
<td>MINERVA KITONG , MD</td>
</tr>
<tr>
<td>Date Information Updated/Filled-up</td>
<td>DIRECTOR, BUREAU OF ADOLESCENT HEALTH AND DEVELOPMENT</td>
</tr>
<tr>
<td>Brief information of your office, agency, or organization</td>
<td>June 17, 2017</td>
</tr>
</tbody>
</table>

**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-GYN, 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.

Health Sector Response to Gender Monitoring and Evaluating Quality

**TABLE 5. Examples of different approaches to monitoring and evaluation**

<table>
<thead>
<tr>
<th>Approach</th>
<th>Examples of Methods</th>
</tr>
</thead>
</table>
| 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 utilization 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.

<table>
<thead>
<tr>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Well-informed, empowered, responsible, and healthy adolescents who are leaders in society</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improve health status of adolescents</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTCOME</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in knowledge, Avoidance of risky behaviors, Practice of protective behaviors, Utilization of services</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPUT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>AHDP</strong></td>
</tr>
<tr>
<td>• Health Workforce</td>
</tr>
<tr>
<td>• Facilities, Logistics, &amp; Commodities</td>
</tr>
<tr>
<td>• Health Services</td>
</tr>
<tr>
<td>• Policy &amp; Governance</td>
</tr>
<tr>
<td>• Financing</td>
</tr>
<tr>
<td>• Strategic Information and M&amp;E</td>
</tr>
<tr>
<td>• Adolescent Participation</td>
</tr>
</tbody>
</table>

Refer to the individual M&E plans of the other component programs for their full list of indicators, including output indicators.
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>
<thead>
<tr>
<th>#</th>
<th>Categories</th>
<th>Indicator</th>
<th>Disaggregation</th>
<th>Source</th>
<th>Baseline (2016)</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Services</td>
<td>Number of people given information on adolescent health (through Health Young Ones)</td>
<td>a. adolescents b. parents c. others</td>
<td>Type of clients (adolescents, parents, health care providers)</td>
<td>Regional AHDP reports</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Services</td>
<td>Number of adolescents assessed using HEEDASSSSS tool</td>
<td>By age and sex</td>
<td>Regional AHDP reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Services</td>
<td>Percentage of adolescents referred to appropriate services</td>
<td>N: # of adolescents referred to appropriate services D: # of adolescents with health risk</td>
<td>Regional AHDP reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Financing</td>
<td>Total expenditure per year of the regional AHDP</td>
<td>By age and sex</td>
<td>Regional AHDP reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Policy &amp; Governance</td>
<td>Percentage of regions with service delivery networks that includes adolescents</td>
<td>N: # of regions with service delivery networks that includes adolescents D: Total # of regions</td>
<td>Regional AHDP reports</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Policy &amp; Governance</td>
<td>Number of policies that promote adolescent health and their access to services</td>
<td>By component program</td>
<td>DOH records review; Regional AHDP reports</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Strategic information and M&amp;E</td>
<td>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</td>
<td>Regional AHDP reports</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*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.

### ANNUAL SCORECARD B: Morbidities, Mortalities, and Risk factors

| # | Cases among adolescents, 10-19 | National | R1 | R2 | R3 | R4A | R4B | R5 | R6 | R7 | R8 | R9 | R10 | R11 | R12 | NCR | CAR | CAR-AGA | ARM/M |
|---|--------------------------------|----------|----|----|----|-----|-----|----|----|----|----|----|-----|-----|----|----|-----|------|
| 1 | Anemia                         |          |    |    |    |     |     |    |    |    |    |    |     |     |    |    |     |      |
| 2 | Dental caries                  |          |    |    |    |     |     |    |    |    |    |    |     |     |    |    |     |      |
| 3 | Teenage pregnancy             |          |    |    |    |     |     |    |    |    |    |    |     |     |    |    |     |      |
| 4 | Adolescent maternal deaths    |          |    |    |    |     |     |    |    |    |    |    |     |     |    |    |     |      |
| 5 | Sexually Transmitted Infections (e.g., Gonorrhea, Syphilis, 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 | | | | | | | | | | | | | | | | |
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>
<thead>
<tr>
<th>#</th>
<th>Categories</th>
<th>Indicator</th>
<th>Source (frequency)</th>
<th>Baseline (Year)</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Nutrition</td>
<td>Prevalence of overweight/obesity among adolescents</td>
<td>N: # of adolescents surveyed who are overweight or obese (based on guidelines)</td>
<td>A: 8.3% (2013)</td>
<td>2020 2022</td>
</tr>
<tr>
<td>2</td>
<td>Nutrition</td>
<td>Prevalence of wasting among adolescents</td>
<td>N: # of adolescents surveyed who are wasted (based on guidelines)</td>
<td>A: 12.4% M: 15% (2013)</td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Nutrition</td>
<td>Reported cases of anemia</td>
<td></td>
<td></td>
<td>No baseline data</td>
</tr>
<tr>
<td>4</td>
<td>Family planning</td>
<td>Adolescent birth rate</td>
<td>N: # of births to women ages 15-19 D: # of adolescents 15-19 X 1,000</td>
<td>NDHS (every 5 years) 57.1 in 1,000 girls 15-19 yo (2013)</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Family planning</td>
<td>Percentage of adolescents who have begun childbearing</td>
<td>NDHS (every 5 years)</td>
<td>15-19 yo: 20% (2013)</td>
<td></td>
</tr>
<tr>
<td>5.1</td>
<td>Family planning</td>
<td>Reported cases of teenage pregnancy</td>
<td>FHSIS (annually)</td>
<td></td>
<td>No baseline data</td>
</tr>
<tr>
<td>6</td>
<td>Safe motherhood</td>
<td>Proportion of adolescent girls who die due to maternal causes</td>
<td>N: # of adolescent girls who die due to maternal causes D: # of adolescent girls who gave birth in a given year X 100,000</td>
<td>CRVS (annually) 128 in 100,000 grts 15-19 yo (2012)</td>
<td></td>
</tr>
<tr>
<td>6.1</td>
<td>Safe motherhood</td>
<td>Reported cases of maternal deaths</td>
<td>BDOH Program Data (annually)</td>
<td></td>
<td>No baseline data</td>
</tr>
</tbody>
</table>

### TABLE 4. Impact indicators per component program (mortalities and morbidities)

<table>
<thead>
<tr>
<th>#</th>
<th>Categories</th>
<th>Indicator</th>
<th>Source (frequency)</th>
<th>Baseline (Year)</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>HIV &amp; STI</td>
<td>STI prevalence among adolescent key populations</td>
<td>N: # of adolescent key populations with syphilis D: # of adolescent key population surveyed</td>
<td>IHBSS (every 2-3 years)</td>
<td>MSM 15-19 yo: 0.82% (2015) FSW 15-19 yo: 0.97% PWID Male 15-19 yo: 0% PWID Female 15-19 yo: 0% (2015)</td>
</tr>
<tr>
<td>7.1</td>
<td>HIV &amp; STI</td>
<td>Reported cases of gonorrhea among adolescents</td>
<td>LABSS (annually)</td>
<td></td>
<td>No baseline data</td>
</tr>
<tr>
<td>8</td>
<td>HIV &amp; STI</td>
<td>HIV prevalence among adolescent key populations</td>
<td>N: # of adolescent key populations with HIV D: # of adolescent key population surveyed</td>
<td>IHBSS (every 2-3 years)</td>
<td>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)</td>
</tr>
<tr>
<td>8.1</td>
<td>HIV &amp; STI</td>
<td>Newly diagnosed cases of HIV among adolescents</td>
<td>HARP (annually)</td>
<td></td>
<td>384 adolescents (2016)</td>
</tr>
<tr>
<td>10</td>
<td>HIV &amp; STI</td>
<td>AIDS-related deaths among adolescents</td>
<td>HARP (annually)</td>
<td></td>
<td>3 adolescents (2016)</td>
</tr>
<tr>
<td>11</td>
<td>Oral Health</td>
<td>Proportion of adolescents with dental caries</td>
<td>National Survey on Oral Health and Nutritional Status</td>
<td>6-12 yo: 92.3% (2005)</td>
<td></td>
</tr>
<tr>
<td>11.1</td>
<td>Oral Health</td>
<td>Reported cases of dental caries</td>
<td>School records?</td>
<td></td>
<td>No baseline data</td>
</tr>
<tr>
<td>12</td>
<td>Oral Health</td>
<td>Proportion of adolescents with periodontitis</td>
<td>BDOH Program Data (annually)</td>
<td></td>
<td>No baseline data</td>
</tr>
</tbody>
</table>
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**

<table>
<thead>
<tr>
<th>#</th>
<th>Categories</th>
<th>Indicator</th>
<th>Source (Frequency)</th>
<th>Baseline (Year)</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>Alcohol</td>
<td>Percentage of adolescents who are binge drinkers</td>
<td>GSHS School-based survey (bi-annually)</td>
<td>All 13-15: 15.5% (2013)</td>
<td>2020 2022</td>
</tr>
<tr>
<td>25</td>
<td>Drugs</td>
<td>Percentage of adolescents who are currently taking dangerous drugs</td>
<td>YAFSS School-based survey (bi-annually)</td>
<td>All 15-24: 4% M: 7.1% F: 0.8% (2013)</td>
<td>2020 2022</td>
</tr>
</tbody>
</table>

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: Knowledge Indicators

<table>
<thead>
<tr>
<th>#</th>
<th>Indicator</th>
<th>Definition</th>
<th>Source/Year</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Percentage of adolescents with correct knowledge on:</td>
<td>N: # of adolescents answering the standard knowledge items* correctly</td>
<td>School-based survey**</td>
<td>65%</td>
<td>75%</td>
</tr>
<tr>
<td>2</td>
<td>a. Nutrition</td>
<td>Correctly selects which food items fall in the green, yellow, and red food categories of the Department of Education</td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>b. Family planning</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>c. Teenage pregnancy</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>d. Nutrition</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>e. Oral health</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>f. Vaccination</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>g. Injury</td>
<td>Correctly identifies the following as ways of preventing road traffic accidents</td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>h. Tobacco use</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>i. Drug use</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>j. HIV</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>k. HIV</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>l. Rubella</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>m. HIV</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>n. Tetanus</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>o. Road traffic accidents</td>
<td></td>
<td>**</td>
<td></td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>p. Teenage maternal deaths</td>
<td></td>
<td>**</td>
<td></td>
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</tr>
<tr>
<td>18</td>
<td>q. Attempted suicide</td>
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<tr>
<td>19</td>
<td>r. Drowning</td>
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<tr>
<td>20</td>
<td>s. Physical violence</td>
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<tr>
<td>21</td>
<td>t. Sexual violence</td>
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<tr>
<td>22</td>
<td>u. % of binge drinkers*</td>
<td></td>
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<tr>
<td>23</td>
<td>v. % of current tobacco users*</td>
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<tr>
<td>24</td>
<td>w. % of regular drug users or drug dependents</td>
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<tr>
<td>#</td>
<td>Component</td>
<td>Indicator</td>
<td>Source (frequency)</td>
<td>Baseline (Year)</td>
<td>Target</td>
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</tr>
<tr>
<td>1</td>
<td>Nutrition (R)</td>
<td>Percentage of adolescents who consumed sugar-sweetened beverages at least twice a week</td>
<td>YAFSS</td>
<td>15-19 yo: 52.6% (2013)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who consumed sugar sweetened beverages (i.e. soda or powdered/bottled juice) at least twice a week</td>
<td>D: # of adolescents surveyed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Nutrition (R)</td>
<td>Percentage of adolescents with a sedentary lifestyle</td>
<td>YAFSS</td>
<td>15-19 yo: 29.9% (2013)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who spend at least 5 hours a day without moving</td>
<td>D: # of adolescents surveyed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Nutrition (R)</td>
<td>Percentage of adolescents who skip breakfast</td>
<td>YAFSS</td>
<td>Program data No baseline data yet.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who skipped breakfast at least xxx times a week</td>
<td>D: # of adolescents surveyed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Nutrition (S)</td>
<td>Percentage of adolescents who completed the weekly IFA supplementation in schools</td>
<td>Program data</td>
<td>No baseline data yet.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who completed the 3-month IFA supplementation</td>
<td>D: # of adolescents targeted</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Family Planning; HIV &amp; STI (R)</td>
<td>Percentage of adolescents with first sex before age 18 years</td>
<td>YAFSS</td>
<td>15-19 yo: 25.7% (2013)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents with first sex before age 18</td>
<td>D: # of adolescents surveyed</td>
<td></td>
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</tr>
<tr>
<td>6</td>
<td>Family Planning (P)</td>
<td>Modern contraceptive prevalence rate among adolescents</td>
<td>NDHS</td>
<td>Female 15-19: 2.4% (2013)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who use modern contraception methods to prevent pregnancy</td>
<td>D: # of adolescents surveyed who engage in sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Family Planning (P)</td>
<td>Percentage of adolescents with unmet family planning needs</td>
<td>NDHS</td>
<td>Female 15-19 yo: 28.7%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of currently married adolescent women with unmet family planning need</td>
<td>D: # of adolescent married women surveyed</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

** All of the knowledge items will be included in the school-based survey.
<table>
<thead>
<tr>
<th>No.</th>
<th>Category</th>
<th>Description</th>
<th>Source</th>
<th>Data Availability</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Safe Motherhood (S)</td>
<td>Percentage of adolescent pregnant mothers who had four (4) antenatal care visits</td>
<td>NDHS</td>
<td>No baseline data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who had 4 ANCs</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: # of adolescents surveyed with live birth in the two years preceding the survey</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Safe Motherhood (S)</td>
<td>Percentage of adolescents births delivered in health facility</td>
<td>NDHS</td>
<td>Female &lt;20: 63.4%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of births delivered in health facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: # of adolescents surveyed with live birth in the five years preceding the survey</td>
<td>Female &lt;20: 63.4%</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Safe Motherhood (S)</td>
<td>Percentage of adolescent births attended by skilled health care provider</td>
<td>NDHS</td>
<td>Female &lt;20: 96.1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of births delivered in health facility</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: # of adolescents surveyed with live birth in the five years preceding the survey</td>
<td>Female &lt;20: 96.1</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Safe Motherhood (S)</td>
<td>Percentage of adolescents pregnant mothers who had postnatal care</td>
<td>NDHS</td>
<td>Female &lt;20: 72.7%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescent pregnant mothers who had postnatal care</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: # of adolescents surveyed with live birth in the two years preceding the survey</td>
<td>Female &lt;20: 72.7%</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>HIV &amp; STI (P)</td>
<td>Percentage of condom use among last sex among adolescent key populations</td>
<td>IHBSS</td>
<td>MSM 15-19 y: 34.82%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who used a condom during last sex</td>
<td></td>
<td>FSW 15-19 y: 64.58%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: # of adolescents key populations surveyed who engage in sex</td>
<td></td>
<td>PWID M 15-19 y: 18.9%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>PWID F 15-19 y: 20%</td>
</tr>
<tr>
<td>13</td>
<td>HIV &amp; STI (P)</td>
<td>Percentage of adolescent people who inject drugs (PWID) who used clean injecting equipment</td>
<td>IHBSS</td>
<td>PWID M 15-19 y: 55.01%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescent PWIDS who use clean injecting equipment</td>
<td></td>
<td>PWID F 15-19 y: 83.33%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: # of adolescent PWIDS surveyed</td>
<td></td>
<td>(2015)</td>
</tr>
<tr>
<td>14</td>
<td>HIV &amp; STI (S)</td>
<td>Percentage of adolescent key populations who had an HIV test and know their status</td>
<td>IHBSS</td>
<td>MSM 15-19y: 8.17% (2015)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who get tested for HIV</td>
<td></td>
<td>FSW 15-19y: 11.2% (2014)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>D: # of adolescent key populations surveyed</td>
<td></td>
<td>PWID M 15-19y: 11% (2015)</td>
</tr>
<tr>
<td>15</td>
<td>HIV &amp; STI (S)</td>
<td>Estimated number of adolescent people living with HIV (PLHIV) who are alive and on ART</td>
<td>HARP, AEM/Spectrum</td>
<td>Female 10-14yo: 5, Male 10-14yo: 1 (2016)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescent PLHIV who are alive and on ART</td>
<td></td>
<td>Female 15-19yo: 17, Male 15-19yo: 457(2016)</td>
</tr>
<tr>
<td>16</td>
<td>Oral Health (P)</td>
<td>Percentage of adolescents who brush their teeth two times a day</td>
<td>School-based survey</td>
<td>No baseline data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who reported brushing their teeth at least two times a day</td>
<td></td>
<td>D: # of adolescents surveyed</td>
</tr>
<tr>
<td>17</td>
<td>Oral Health (S)</td>
<td>Percentage of adolescents who go to the dentist every three months</td>
<td>School-based survey</td>
<td>No baseline data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who reported going to the dentist at least every 3 months</td>
<td></td>
<td>D: # of adolescents surveyed</td>
</tr>
<tr>
<td>18</td>
<td>Vaccine Preventable Diseases’/ VPD (S)</td>
<td>Percentage of female adolescents 9-10 years with complete HPV vaccination</td>
<td>Program data</td>
<td>No age-disaggregated baseline data.</td>
</tr>
<tr>
<td>19</td>
<td>Vaccine Preventable Diseases’/ VPD (S)</td>
<td>Percentage of adolescents 12-13 years with complete MMR/DT vaccination</td>
<td>Program data</td>
<td>No age-disaggregated baseline data.</td>
</tr>
<tr>
<td>20</td>
<td>Mental health (R)</td>
<td>Percentage of adolescents who ever thought of committing suicide</td>
<td>YAFSS</td>
<td>15-19 y: 7.3% (2013)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who reported ever thinking of committing suicide</td>
<td></td>
<td>D: # of adolescents surveyed</td>
</tr>
<tr>
<td>21</td>
<td>Mental health (P)</td>
<td>Percentage of adolescents who tend to bounce back quickly after hard times</td>
<td>School-based survey</td>
<td>No baseline data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who reported being able to bounce back quickly after hard times (6 or more in a scale of 1-10)</td>
<td></td>
<td>D: # of adolescents surveyed</td>
</tr>
<tr>
<td>22</td>
<td>Mental health (P)</td>
<td>Percentage of adolescents who have a hard time making it through stressful events</td>
<td>School-based survey</td>
<td>No baseline data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who reported being having a hard time making it through stressful events (6 or more in a scale of 1-10)</td>
<td></td>
<td>D: # of adolescents surveyed</td>
</tr>
<tr>
<td>23</td>
<td>Mental health (S)</td>
<td>Percentage of adolescents accessing mental health services</td>
<td>Program data</td>
<td>No baseline data</td>
</tr>
<tr>
<td>24</td>
<td>Violence (S)</td>
<td>Percentage of adolescent cases managed by VAWC within 12 months</td>
<td>VAWC RS</td>
<td>No baseline data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>a. Medical needs managed</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>b. Psychological needs managed</td>
<td></td>
<td></td>
</tr>
<tr>
<td>25</td>
<td>Injury (P)</td>
<td>Percentage of adolescents who wear a helmet when driving or riding a motorcycle</td>
<td>School-based survey</td>
<td>No baseline data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who reported wearing a helmet every time they drive or ride a motorcycle</td>
<td></td>
<td>D: # of adolescents surveyed who drive or ride a motorcycle</td>
</tr>
<tr>
<td>26</td>
<td>Injury (P)</td>
<td>Percentage of adolescents who wear a seat belt when driving or riding a car</td>
<td>School-based survey</td>
<td>No baseline data</td>
</tr>
<tr>
<td></td>
<td></td>
<td>N: # of adolescents who reported wearing a seat belt every time they drive or ride a car</td>
<td></td>
<td>D: # of adolescents surveyed who drive or ride a car</td>
</tr>
</tbody>
</table>

**Note:** Some data sources are not specified, and some data may be from baseline surveys. For complete and reliable data, cross-referencing with primary sources is recommended.
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
N: # of adolescents who reported refusing drugs  School-based survey  No baseline data.

29. Drugs (R)  Percentage of adolescents who did not use prohibited drugs within school premises
D: # of adolescents who used 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  IDA/DIN annually  No baseline data.

31. Alcohol (P)  Percentage of adolescents who did not drink alcohol within school premises
D: # of adolescents who drank 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
D: # of adolescents who smoked within school premises  School-based survey  No baseline data.

7.6 Data sources and flow of reporting

i. Philippine Health 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 Nataality, 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 morbidity 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 (IHBBSS)
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 IHBBSS 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 IHBBSS 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 enrollment, 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 to gather 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. National 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 stakeholders’ 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 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.
Annex A.

National Policy and Strategic Framework on Adolescent Health and Development

Republic of the Philippines
Department of Health
OFFICE OF THE SECRETARY

ADMINISTRATIVE ORDER
No. 2013 - 0613

SUBJECT: National Policy and Strategic Framework on Adolescent Health and Development

I. BACKGROUND AND RATIONALE

The twenty million (20,844,378) adolescents age 10-19 years comprised 28% of the country’s population (NSO, 2016). 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 rates in this age group are low, they are susceptible to conditions that are related to their increased mobility, socialization (Valentin-Torres, 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. Seven (7) percent of abortive 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, 2012). Three percent of young people ages 15-24 have attempted to commit suicide (UPPI/DOH, 2007). Acts of assault and bullying are also causing increasing concern among parents, educators and adolescents themselves.

Administrative Order 26-A, s 2006, the Adolescent and Youth Health (AYH) Policy formulated in April 2006, 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 attuned 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 on Adolescent and Youth Health Program (AYHP), composed of both government and non-government organizations dedicated in spelling the welfare of adolescents and called to revalidate 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 (NDDC) drafted a National Standards and Implementing Guide for Adolescent Friends Health Facility; an Adolescent Job Aid Manual and a Primer on Legal Issues 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...
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.
7. AO 2006-0029 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

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 who 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 7611).
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 parenthood: 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
133132

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.

3. 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 (Philipp, 2002) mortality, low birth weight babies (NSO), and limiting of the woman’s education and livelihood opportunities.

4. 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 violence; and (6) Mental health. (National Standards and Implementation Guide for the Provision of Adolescent-Friendly Health Services, DOH, 2010)

4.1 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. 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 8571, Adolescents (Persons) with Disability (RA 9442), Adolescents (Children) in Conflict with the Law (RA 9344), Drug-dependent Adolescents (RA 9185), 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. 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 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 a 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.

3. 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 continues 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
      women (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)

VIII. IMPLEMENTATIONAL 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 (NCPH), 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 AHDP
   - 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

• 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 multidisciplinary teams for Women and Child Protection Units and sustain 24/7 Crisis Interventions 24/7 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 benefit 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
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. 2006, 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

h. 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.

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.

i. Youth: Bedrock of Humanitarian Response | Typhoon Washi, Typhoon Bopha, Typhoon Haiyan
j. 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.

k. 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)

l. 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.
m. 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.

n. 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 nagbibigay-gabay ng mga City/Municipal Link o Resource Person sa kanilang pangangasiwa sa buwanang FDS at paghikayat sa mga benepisyaryo na tabuhay ang kanilang natutunan mula rito. Ito ay nahahati sa mga sumusunod na Modyul

Modyul 1: Pagalatag ng Pundasyon ng Pantawid Pamilyang Pilipino Program

Modyul 2: Paghahanda at Pangangalaga ng Pamilyang Pilipino
Ang Pangalawang Modyul naman ay naglalayong palakasin at patatagin ang mga pamilya upang sila ay maging aktiboong kalahok sa pagtataguyod ng pagbabago ng kanilang kalagayan. Ang Modyul na ito ang may magalatang perspektibo ng pagtuturuan ng mga pangangalaga sa pamilya. Sinisimulang nito ang pagtalakay sa paghahanda ng mga pamilya at pagpapatupad sa pagpapakita ng mga pangangalaga sa mga babaeng, bata at ang mga Katutubong Pilipino.

Modyul 3: Partisipasyon ng Pamilyang Pilipino sa Gawaing Pangkomunidad
Ang huling Modyul ay naglalaman ng mga paksang tumatalakay sa mga usaping pangkomunidad na maaaring gamitin sa harap ng mga pamilya para naaniin yung mga pangalan ng mga pamilya sa kanilang 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.

I. Learning Package on Parent Education on Adolescent Health and Development (LPED)
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 pregnancy.

Enumerate the risks of teen pregnancy
Identify the care and medical needs and corresponding expenses for a healthy 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.

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

Annex D

Collated Menu of Global AHDP Indicators and definitions

Annex C Menu of Indicators and definitions

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

<table>
<thead>
<tr>
<th>Age/ Sex</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-14 years</td>
<td>5.3%</td>
<td>5.1%</td>
<td>10.4%</td>
</tr>
<tr>
<td>15-19 years</td>
<td>5.2%</td>
<td>5.0%</td>
<td>10.2%</td>
</tr>
<tr>
<td>Total</td>
<td>10.5%</td>
<td>10.1%</td>
<td>20.6%</td>
</tr>
</tbody>
</table>

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
## Menu of Indicators

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

### Proportion of adolescents who have experienced gender-based violence

| 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 NNS |

### Proportion of adolescents who have felt sadness or loneliness severe enough to affect their usual activities or have had thoughts of harming or killing themselves

| Proportion of adolescents who have felt sadness or loneliness severe enough to affect their usual activities or have had thoughts of harming or killing themselves | Percentage of all 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

| 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

| 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 community activity in the past 6 months | # 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

| 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 |

---

**Manual of Operations on Adolescent Health and Development Program for Program Managers**

150 151
### Capacity Building

<table>
<thead>
<tr>
<th>% RHU midwives, nurses, and doctors who say they are confident that they can talk to adolescents about sex, suicide, substance abuse, and other topics</th>
<th>Survey</th>
</tr>
</thead>
<tbody>
<tr>
<td>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</td>
<td>Survey</td>
</tr>
<tr>
<td>Number of youth-led advocacy initiatives</td>
<td>Environmental scan</td>
</tr>
<tr>
<td>Number of project proposals from youth organizations that are funded</td>
<td>Environmental scan</td>
</tr>
</tbody>
</table>

### Program Sustainability

<table>
<thead>
<tr>
<th>Funding: A strategy to ensure sustainable financing of the AHDP is developed</th>
<th>Environmental scan</th>
</tr>
</thead>
<tbody>
<tr>
<td>M&amp;E: An effective system for gathering and accessing reliable and accurate information for programming decisions is in place</td>
<td>Environmental scan</td>
</tr>
<tr>
<td>Research: Current gaps in data are addressed by research endeavours</td>
<td>Environmental scan</td>
</tr>
<tr>
<td>Partnerships: Stakeholders express support for AHDP Strategic Plan</td>
<td>Environmental scan</td>
</tr>
<tr>
<td>Policy advocacy: LGU passes or enforces ordinance on AHDP</td>
<td>Environmental scan</td>
</tr>
<tr>
<td>Policy advocacy: LGU provides funding for AHDP</td>
<td>Environmental scan</td>
</tr>
</tbody>
</table>

### Annex E

**Program Monitoring and Reporting Forms**

**Table 2. AHDP Monitoring Tool**
### Table 3. Annual Scorecard A: Adolescent Health and Development Program (AHDP) Indicators

<table>
<thead>
<tr>
<th>Program Area</th>
<th>MISP SRH Services</th>
<th>Planning for Comprehensive SRH Services</th>
</tr>
</thead>
</table>
| 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
- Ensure 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-retroviral (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
- 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.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Input Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Basic</td>
</tr>
<tr>
<td>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</td>
<td>Basic</td>
</tr>
<tr>
<td>3. Health services to adolescents free of charge or at affordable prices are in place</td>
<td>Enhanced</td>
</tr>
<tr>
<td>4. Flexible time schedule for adolescent clients</td>
<td></td>
</tr>
<tr>
<td>5. Provide outreach health services to adolescents, particularly those belonging to special groups</td>
<td></td>
</tr>
<tr>
<td>6. Package of services provided to adolescents</td>
<td></td>
</tr>
<tr>
<td>7. Essential commodities and supplies</td>
<td></td>
</tr>
<tr>
<td>8. Designated focal person for adolescent-friendly health services</td>
<td></td>
</tr>
<tr>
<td>9. Service providers have been trained and are competent in managing adolescent clients</td>
<td></td>
</tr>
<tr>
<td>10. Protocols / guidelines to provide services in non-judgmental, caring, considerate, gender and culturally-sensitive attitude and manner</td>
<td></td>
</tr>
<tr>
<td>11. Clinical management guidelines for the provision of the specified health services (Adolescent Job Aid)</td>
<td></td>
</tr>
<tr>
<td>12. Resource directory of organizations and referral networks</td>
<td></td>
</tr>
<tr>
<td>13. System and forms for referral and return referral</td>
<td></td>
</tr>
<tr>
<td>Standard</td>
<td>Input Criteria</td>
</tr>
<tr>
<td>----------</td>
<td>---------------</td>
</tr>
<tr>
<td>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.</td>
<td>Basic</td>
</tr>
</tbody>
</table>
| 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 fulfill 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. |     |     |    |
| 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. |     |     |    |

<table>
<thead>
<tr>
<th>Standard</th>
<th>Input Criteria</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>Basic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20. Procedures to communicate with all adults visiting the health facility about the value of providing adolescents with services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21. Some health services and commodities to adolescents provided by selected community members, NGOs, outreach workers and adolescents themselves.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22. Advocating for support for provision of services for adolescents in the local development plan.</td>
<td>Enhanced</td>
<td></td>
<td></td>
</tr>
<tr>
<td>23. Activities (including community assemblies, meetings with parents, group meetings and school visits) to engage community members in providing adolescent health services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
DOH Department Memorandum on Adolescent Friendly Health Facility Standard Evaluation Tool

January 24, 2017

DEPARTMENT MEMORANDUM
No. 2017- __06-FF

TO: ALL REGIONAL DIRECTORS AND CHIEFS OF HOSPITALS

SUBJECT: Adolescent Friendly Health Facility Standard Evaluation Tool

The Adolescent Friendly Health Facility (AFHF) standards were drafted 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

---

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

Monitoring Team: ____________________________ Date and Time of Monitoring: ____________

---

ALL FOR HEALTH, HEALTH FOR ALL
## Monitoring Tool 2. Facility Observation Checklist

**Department of Health**

**Republic of the Philippines**

**Office of the Secretary**

### Region:

### Province:

### Municipality:

### Level 2 Health Facility

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

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

---

**ALL FOR HEALTH | HEALTH FOR ALL**

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**Building 1, San Lazaro Compound, Rizal Avenue, Sta. Cruz, 1003 Manila ● T R U S T Line 651-7000 local 1113, 1108, 1135
Donor Line: 711-9502, 711-9503 Fax: 743-1829 ● URL: http://www.doh.gov.ph e-mail: cfo@health.gov.ph**
## Monitoring Tool 3: Facility Observation Checklist

**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.

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

Client Satisfactory Survey

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;

WITNESSETH:

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 actually 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 management 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 activity 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:

____________________

____________________
Annex I Sample Forms

a. Client Satisfactory Survey

**ADOLESCENT CLIENT SATISFACTION SURVEY**

Thank you for assessing 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 services did you avail? (List below)

Check the box that corresponds to your answer:

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

**ADOLESCENT CLIENT SATISFACTION SURVEY**

Thank you for assessing our services!

We hope you can answer this short survey to help us improve in the future.

**Name of Facility:** ____________________________  **Location:** ____________________________

**Age:** ______  **Sex:** M F  **Average Rating:** ______

1. What services did you avail? (List below)

Check the box that corresponds to your answer:

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

Client Satisfaction Survey adapted from UNICEF Philippines
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/DETECTION: ___________________________  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. Transcendental 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 volume of the testes

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

6. When do you ask for pelvic exams?
   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 discloses 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 15-year-old teacher.

C. Arrange the steps in proper order:

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

1. Ask the adolescent to introduce his/her companion.
2. Discuss the format of the visit, define confidentiality, and the need to see the adolescent alone.
3. Greet and introduce yourself to the adolescent.
4. Call back the patient’s Companion and wrap up the consultation with both in [side] the room.
5. 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 anybody 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 ______ you self or others and you are experiencing physical or sexual ______

E. True or False

1. Privacy refers to the right of an individual to keep his/her information private ______
2. 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.

<table>
<thead>
<tr>
<th>Column A</th>
<th>Column B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Accessibility</td>
<td>A. The facility has a well-trained staff.</td>
</tr>
<tr>
<td>2. Appropriateness</td>
<td>B. The health facility is easy to reach.</td>
</tr>
</tbody>
</table>

_____3. Affordability
_____4. Comprehensiveness
_____5. Efficiency

C. Services address both the medical and psychosocial needs of the adolescents.
D. Services respond to the needs of adolescents

Checked by: ___________________________
Signature over printed Name

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

HIV and AIDS PRE-TEST QUESTIONNAIRE

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

Encircle the letter of the correct answer

1. Untreated HIV infection 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, EXCEPT:
   a. Sexual intercourse
   b. Blood transfusion
   c. Pregnant mother
   d. Sharing of food with a w/o condom

3. A mother can transmit HIV to her child through all means, EXCEPT:
   a. Pregnancy
   b. 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

d. Service Provider Self Assessment Form

**Staff Self-Assessment Form**

**Adolescent Health Care and Development Provider**

**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.

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

<table>
<thead>
<tr>
<th>Service Provider</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did I greet the adolescent politely and make him comfortable?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I introduce myself the teens and his/her companion?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I call her by her name during the whole session?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I reiterate / assure the importance of confidentiality and privacy to my patient?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I ask permission from my adolescent patient when taking notes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I assure that no interruptions/phone calls that disrupt the patient during the interview?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I allow the patient to talk freely?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Is the examination area protected from view of other people?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I ask/seek permission, inform, and explain the procedure of the medical examination?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Prescribing a course of treatment

<table>
<thead>
<tr>
<th>Prescribing a course of treatment</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did I ask histories of allergies (food and drugs)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I explain what the treatment is all about and how it is taken (with written instructions)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I explain possible side effects and explain how to manage them?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Ending the examination

<table>
<thead>
<tr>
<th>Ending the examination</th>
<th>Yes</th>
<th>No</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did I summarize the most important information that the patient has to understand?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I provide a two way referral slip and explain where, how, and when the client can go to avail of the needed services?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did we agree on the return visit?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did I assure the patient again that the discussion is confidential and private?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

### Referral Form

**REFERRAL FORM**

(To be left in the Referral Facility)

<table>
<thead>
<tr>
<th>Reference number:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Name of Referring Facility:</td>
<td></td>
</tr>
<tr>
<td>Address:</td>
<td>Tel No:</td>
</tr>
<tr>
<td>Name/Position of Service Provider Referring:</td>
<td>Date of Referral:</td>
</tr>
<tr>
<td>Name of the facility to which the client is being referred:</td>
<td></td>
</tr>
<tr>
<td>Name of Client:</td>
<td>Age:</td>
</tr>
<tr>
<td>Address:</td>
<td></td>
</tr>
<tr>
<td>Reason for Referral:</td>
<td></td>
</tr>
<tr>
<td>Brief History (Include pertinent PE and laboratory findings and actions taken, if any.):</td>
<td></td>
</tr>
<tr>
<td>Clinical Impression:</td>
<td></td>
</tr>
</tbody>
</table>

**REFERRAL RETURN SLIP**

(Please cut and instruct patient/guardian to deliver back to Referring Facility)

| Signature of Person Referring | Signature Over Printed Name of Client/Guardian: |     |
Section 1 sample activities

HOW TO INTRODUCE THIS TOPIC TO STAKEHOLDERS

Use of body map or ‘lumalaki-tumutubo-nagkakaron’ 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-nagkakaron

- 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 5)
- 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?

Section 3 sample activities

Program development cycle

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.

---

### Program Matrix

#### Instructions:

- Problem: See Section 4 - Health Outcomes
- Impact: Score 3 if the problem most affects the health and development of adolescents
- Size or magnitude of the problem: Score 3 if the problem affects the most number of people
- Cost of intervention: Score 3 if low-cost interventions can be used
- Availability of resources: Score 3 if manpower, machines, and money are available to address this problem
- Urgency of the problem: Score 3 if not addressing it now will be the most damaging to adolescents and the community
- Write your chosen health problems under “Health Status (Outcome)” in Worksheet 3: Program Matrix.

#### 1a: Priority Health Problems (blank)

<table>
<thead>
<tr>
<th>Health Outcome</th>
<th>Problem</th>
<th>Criteria 1 (low), 2 (moderate), or 3 (high)</th>
<th>Total Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Healthy Development</td>
<td>e.g. obesity</td>
<td>1 1 2 1 1</td>
<td>6 (lower priority)</td>
</tr>
<tr>
<td>Healthy Nutrition &amp; Physical Activity</td>
<td>e.g. anaemia</td>
<td>2 3 1 1 2</td>
<td>8 (high priority)</td>
</tr>
<tr>
<td>Sexual and Reproductive Health</td>
<td>e.g. early pregnancy</td>
<td>3 3 3 3 3</td>
<td>15 (highest priority)</td>
</tr>
</tbody>
</table>

---
Mental health

Services in crisis situations

Supportive environment

Increased service utilization

Participation in community development

2: SWOT Analysis (sample)

2a: SWOT Analysis (blank)

<table>
<thead>
<tr>
<th>INTERNAL</th>
<th>EXTERNAL</th>
</tr>
</thead>
</table>
| **Strengths**
90% of health staff trained in AJA
One health centre per barangay
Municipal hospital with 100 beds
Peer educators trained by POPCOM | **Weaknesses**
Turnover of health staff
No budget for allowances of volunteers |

<table>
<thead>
<tr>
<th>INTERNAL</th>
<th>EXTERNAL</th>
</tr>
</thead>
</table>
| **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 | **Threats**
7 out of 12 city councillors are anti-RH |

3: Program Matrix (sample)

<table>
<thead>
<tr>
<th>Narrative</th>
<th>Indicators and Targets</th>
<th>Source of Data</th>
<th>Important Assumptions</th>
</tr>
</thead>
</table>
| **Vision (Goals)**
• Improved health status of adolescents
• Adolescents fully enjoy their right to health | **Health Status (Outcome) 1:**
- Early pregnancies are reduced | **Source of Data** | **Important Assumptions** |
| | 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)**

<table>
<thead>
<tr>
<th>Narrative</th>
<th>Indicators and Targets</th>
<th>Source of Data</th>
<th>Important Assumptions</th>
<th>Source of Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vision (Goals)</td>
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<tr>
<td>Health Status (Outcome) 1</td>
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<tr>
<td>Strategy (Output) 1.1</td>
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<tr>
<td>Major Activities</td>
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<td>Strategy (Output) 1.2</td>
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<td>Major Activities</td>
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<td>Strategy (Output) 1.3</td>
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<tr>
<td>Major Activities</td>
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<tr>
<td>Health Status (Outcome) 2</td>
<td></td>
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<tr>
<td>Strategy (Output) 2.1</td>
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<tr>
<td>Major Activities</td>
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<td></td>
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<tr>
<td>Output 2.2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major Activities</td>
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</tbody>
</table>

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**4: Results Chain (sample)**

<table>
<thead>
<tr>
<th>Major Activities</th>
<th>Outputs/ Strategies</th>
<th>Behavioral Outcomes</th>
<th>Health Status Outcome</th>
<th>Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Training for health service providers and teachers</td>
<td>Adolescent-friendly health services will be available in schools, including provision of contraceptives with parent’s consent</td>
<td>Adolescents practice safer sex</td>
<td>Early pregnancies are reduced</td>
<td>Improved health status of adolescents</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Training of peer educators</th>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>Capacitating peer educators on behavior change and health education</td>
<td></td>
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</tr>
</tbody>
</table>
### 5: Short-term Activity Plan (sample)

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

### 5a: Short-term Activity Plan (blank)

<table>
<thead>
<tr>
<th>Indicators and Targets</th>
<th>Program Strategies</th>
<th>Activities</th>
<th>Resources Needed</th>
<th>Person Responsible</th>
<th>Timeframe</th>
<th>Budget Source</th>
</tr>
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</tbody>
</table>

### 6: Checklist of Services and Providers (sample)

<table>
<thead>
<tr>
<th>Services</th>
<th>Name of Service Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><a href="#">General Health Assessment - History and Physical Exam</a></td>
<td>ABGH, CDH, KlinikaEF, Dr. GH, NGO, Inc.</td>
</tr>
<tr>
<td><a href="#">Dental Assessment</a></td>
<td>ABGH, CDH, KlinikaEF, Dr. GH, NGO, Inc.</td>
</tr>
<tr>
<td><a href="#">Psychosocial Risk Assessment and Management</a></td>
<td>ABGH, CDH, KlinikaEF, Dr. GH, NGO, Inc.</td>
</tr>
<tr>
<td><a href="#">Nutrition Assessment &amp; Counselling</a></td>
<td>ABGH, CDH, KlinikaEF, Dr. GH, NGO, Inc.</td>
</tr>
<tr>
<td><a href="#">Micronutrient Supplementation</a></td>
<td>ABGH, CDH, KlinikaEF, Dr. GH, NGO, Inc.</td>
</tr>
<tr>
<td><a href="#">Immunization</a></td>
<td>ABGH, CDH, KlinikaEF, Dr. GH, NGO, Inc.</td>
</tr>
</tbody>
</table>
### 6a: Checklist of Services and Providers (blank)

<table>
<thead>
<tr>
<th>Services</th>
<th>Name of Service Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Basic Services</strong></td>
<td></td>
</tr>
<tr>
<td>General Health Assessment – History and Physical Exam</td>
<td></td>
</tr>
<tr>
<td>Dental Assessment</td>
<td></td>
</tr>
<tr>
<td>Psychosocial Risk Assessment and Management</td>
<td></td>
</tr>
<tr>
<td>Nutrition Assessment &amp; Counselling</td>
<td></td>
</tr>
<tr>
<td>Micronutrient Supplementation</td>
<td></td>
</tr>
<tr>
<td>Immunization</td>
<td></td>
</tr>
<tr>
<td>Basic Diagnostic Tests</td>
<td></td>
</tr>
<tr>
<td>Reproductive Health Assessment and Counselling</td>
<td></td>
</tr>
<tr>
<td>Fertility awareness, menstrual health issues, sexual and reproductive health counselling including contraceptive counselling</td>
<td></td>
</tr>
<tr>
<td>Pap smear and pelvic exam if sexually active</td>
<td></td>
</tr>
<tr>
<td>Adolescent male reproductive health issues</td>
<td></td>
</tr>
<tr>
<td>Gender issues (VAWC Desk)</td>
<td></td>
</tr>
<tr>
<td>Voluntary Counselling and Testing for STIs and HIV</td>
<td></td>
</tr>
<tr>
<td>Risk Assessment (HEADSS)</td>
<td></td>
</tr>
<tr>
<td><strong>Prenatal</strong></td>
<td></td>
</tr>
<tr>
<td>Prevention of Adolescent Pregnancy</td>
<td></td>
</tr>
<tr>
<td>Health education sessions</td>
<td></td>
</tr>
<tr>
<td>Counselling</td>
<td></td>
</tr>
<tr>
<td>Prenatal History and Physical Examination</td>
<td></td>
</tr>
<tr>
<td>Immunization – Tetanus toxoid</td>
<td></td>
</tr>
<tr>
<td>Micronutrient supplementation with iron, folate</td>
<td></td>
</tr>
<tr>
<td>Psychosocial risk assessment</td>
<td></td>
</tr>
<tr>
<td>Laboratory – CBC, blood typing (if not available, refer) pregnancy test, urinalysis</td>
<td></td>
</tr>
<tr>
<td>Pregnancy counselling</td>
<td></td>
</tr>
<tr>
<td>Nutrition counselling</td>
<td></td>
</tr>
<tr>
<td>Birth plan including exclusive breastfeeding counselling</td>
<td></td>
</tr>
<tr>
<td>Family planning counselling</td>
<td></td>
</tr>
<tr>
<td>HBsAg test for pregnant mothers</td>
<td></td>
</tr>
<tr>
<td><strong>Natal (Birthing Homes)</strong></td>
<td></td>
</tr>
<tr>
<td>Safe delivery by skilled health worker at a mother-and baby friendly health facility</td>
<td></td>
</tr>
<tr>
<td>Essential Newborn Care</td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>Name of Service Providers</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>Protocol</td>
<td></td>
</tr>
<tr>
<td>Newborn package: Vitamin K, Hepatitis B – birth dose, BCG, eye prophylaxis, Newborn Screening</td>
<td></td>
</tr>
<tr>
<td>Postnatal</td>
<td></td>
</tr>
<tr>
<td>Micronutrient Iron supplementation</td>
<td></td>
</tr>
<tr>
<td>Counselling services: Family planning, Nutrition counselling, Exclusive Breastfeeding, Parenting</td>
<td></td>
</tr>
<tr>
<td>Provision of FP services and commodities (with parental consent)</td>
<td></td>
</tr>
<tr>
<td>Sexually Transmitted Infections/HIV Packages</td>
<td></td>
</tr>
<tr>
<td>STI and HIV Risk Assessment</td>
<td></td>
</tr>
<tr>
<td>Diagnostics: Gram Stain, RPR, C/S, HIV Counselling and or Testing</td>
<td></td>
</tr>
<tr>
<td>Risk Reduction Counselling</td>
<td></td>
</tr>
<tr>
<td>Voluntary Counselling and Testing for HIV/STIs</td>
<td></td>
</tr>
<tr>
<td>Health Education</td>
<td></td>
</tr>
<tr>
<td>Conduct of Adolescent Health sessions among in-school adolescents</td>
<td></td>
</tr>
<tr>
<td>Conduct of Adolescent Health sessions among out-of-school adolescents</td>
<td></td>
</tr>
<tr>
<td>Conduct of Parent Education sessions among parents of adolescents</td>
<td></td>
</tr>
<tr>
<td>Other Services</td>
<td></td>
</tr>
</tbody>
</table>

7: Stakeholders Analysis (sample)

<table>
<thead>
<tr>
<th>More powerful</th>
<th>Supportive</th>
<th>Less powerful</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Mayor</td>
<td>• SB Health</td>
<td>• Bishop</td>
</tr>
<tr>
<td>• Vice Mayor</td>
<td>• SK Chair</td>
<td>• CSOs</td>
</tr>
<tr>
<td>• Opposed</td>
<td>• SSG-NHS</td>
<td></td>
</tr>
</tbody>
</table>

7a: Stakeholders Analysis (blank)

<table>
<thead>
<tr>
<th>More powerful</th>
<th>Supportive</th>
<th>Less powerful</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>
## 8: Information on Health Providers (sample)

Province:
City/ Municipality:

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

## 8a: Information on Health Providers (blank)

Province:
City/ Municipality:

<table>
<thead>
<tr>
<th>Name of Service Provider</th>
<th>Address &amp; Phone No.</th>
<th>Services Offered</th>
<th>Clientele Accreditation Status</th>
<th>Type (public/private)</th>
<th>Clinic Hours/ Schedule</th>
<th>Cost of Services</th>
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</tbody>
</table>
### 9: Partner Mapping (sample)

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

### 9a: Partner Mapping (blank)

<table>
<thead>
<tr>
<th>Partner/ Ally</th>
<th>Description</th>
<th>Value of Cooperation</th>
<th>Tactics for Collaboration</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

### 10: Advocacy Plan (sample)

<table>
<thead>
<tr>
<th>Policy Change Objective</th>
<th>Target Policymakers</th>
<th>Channels to Reach Policymakers</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. Enact a municipal ordinance on the Service Delivery Network for adolescents</td>
<td>Sangguniang Bayan (SB) Mayor</td>
<td>Presentation during regular SB meeting Lobbying (one-on-one) Petition signing</td>
<td>Developed advocacy plan with SDN members Got agreement from Mayor to proceed Presented draft of proposed ordinance to city council Passage of ordinance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy Change Objective</th>
<th>Target Policymakers</th>
<th>Channels to Reach Policymakers</th>
<th>Milestones</th>
</tr>
</thead>
<tbody>
<tr>
<td>e.g. Enforce the curfew for minors</td>
<td>Barangay Chairman Barangay Tanods</td>
<td>Meeting with Barangay Chairman and Tanods</td>
<td></td>
</tr>
</tbody>
</table>
Annex L

AHDP Technical Working Group Department Order

DEPARTMENT PERSONNEL ORDER
No. 2017 - 2799

SUBJECT: Creation of the Technical Working Group for Adolescent Health and Development

I. BACKGROUND AND RATIONALE

Twenty-one percent or roughly 20 million of the total population of the Philippines is comprised of adolescents, aged 10-19 years (NSO, 2010). Adolescent face many threats to their health and well-being. Depression and drug use are among the top five causes of death among the 10-14 and 15-19 age groups (DOH, 2008). A study in 2015 (Youth and Adolescent Fertility Survey) showed that 1 in 3 adolescents, aged 15-19 years old, reported having sexual encounters and that 78 percent of these sexual debut are unprotected.

Another feature that can be observed is the steadily increasing rate of adolescent pregnancy, the same study presented that from 9.3 percent in 2002, the percentage of girls aged 15-19 years old who are mothers or pregnant for the first time rose to 12.6 percent. The 2015 Global School-based Student Health Survey (GSHS) found that 16.3% of students, ages 13-17 have attempted suicide once or more times during the 12 months before the survey was conducted. On the same survey, 18.8% of students ages 13-17 are currently using any tobacco products. The first Philippine National Baseline on Violence against Children showed 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 50% of the estimated new HIV infections come from Filipinos who are 15 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 NEV and AIDS and ART Registry in the Philippines (HASP) 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 a person’s life. This agenda, through the Family Health Office, issued Administrative Order No. 2013-0013 (National Policy and Strategic Framework on Adolescent Health and Development) established 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 concerns.

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 convenor agency that will focus on the health concerns of the adolescents, and the National Youth Commission (NYC) will be the co-convenor agency 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 Divisions: Harmful Use of Alcohol
12. Lifestyle Related Diseases Divisions: 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 Kabahayan (LiKhaan)
11. The Family Planning Organization of the Philippines
12. Technical Education and Skills Development Authority
13. Women Health 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, academic, youth-led organizations, councils, specializations, and other groups as resource persons and can provide inputs in 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)
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 upon 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 J. BOSSELL, MD, MPH, CESO II
Secretary of Health

[Signature]
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 follow-up, 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 is his/her 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 follow-up, 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 (RCHUs), and Barangay Health Stations (BHS). Thus, a manual of operations was developed with support from the World Health Organization (WHO) Philippines 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

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Day 1

1:00-2:30  Biological and Psychosocial Changes in Adolescence  Lumalaki, Tumutubo, Nagkakaroon (See pages 15-20 and Annex R)

2:30-3:30  AID 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  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.

Step 6: Implement and monitor

Step 7: Assess and evaluate

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

6. U4U http://u4u.ph/home
12. Global School-Based Student Health Survey (GSHS). World Health Organization. Department of Health, Philippines
15. DOH HIV AIDS and ART Registry of the Philippines April 2017

Annex P

Additional Resources

3. Global School-Based Student Health Survey (GSHS). World Health Organization. Department of Health, Philippines
7. DOH HIV AIDS and ART Registry of the Philippines April 2017
Other Resources


5. Conaco, C, Jimenez, C, and Billeco C. Filipino adolescents in changing times. 2003. UPCenter for Women's Studies and Philippine Center for Population and Development


17. Adapted from The International Save the Children Alliance. Advocacy Matters: Helping children change their world. 2007.


20. Ujano-Batangan, Maria Theresa. Promoting adolescents’ sexual health through responsive-supportive parenting. HAIN and DRDF-UPPI. (YAFS3)


42. Steinberg, Laurence. Risk Taking in Adolescence: New Perspectives from Brain and Behavioural Science. Current Directions in Psychological Science


Contact persons for this MOP; in case of further inquiries, suggestions or comments, which can be relevant for future versions.

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