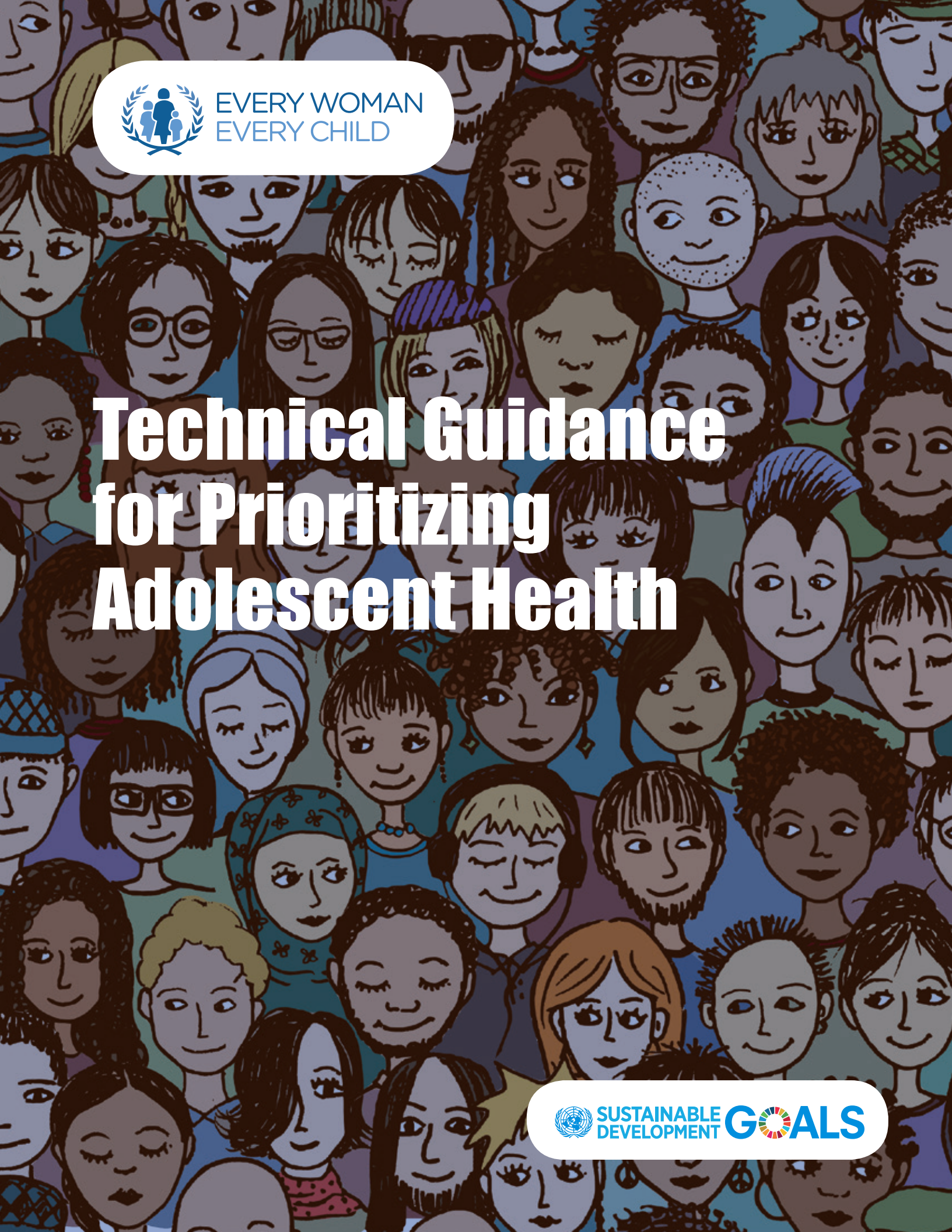
EVERY WOMAN
EVERY CHILD
Technical Guidance for Prioritizing Adolescent Health
SUSTAINABLE DEVELOPMENT GOALS

Every Woman Every Child is an unprecedented global effort that mobilizes and intensifies international and national action to address the major health challenges facing women, children and adolescents.

It envisions a world in which every woman, child and adolescent, everywhere, can not only realize their rights to physical and mental health and wellbeing, but also achieve their full potential, seize opportunities, and participate fully in shaping more inclusive, resilient, prosperous and sustainable societies.

EWEC puts into action the *Global Strategy for Women's Children's and Adolescents' Health,* fostering its implementation through three pillars:

- Survive (ending preventable deaths),
- Thrive (ensuring health and wellbeing) and
- Transform (expanding enabling environments).

The *Global Strategy* is fully aligned with the Sustainable Development Goals (SDGs) and contributes to their full achievement. It provides a strategic roadmap to achieve health related targets, and recommends multistakeholder collaboration across sectors to scale-up effective interventions to ensure the health and well-being of all women, children and adolescents.

For more information, visit: www.everywomaneverychild.org/

The *Global Strategy* provides a holistic view, with recommendations going beyond survival and drawing linkages to other areas, including nutrition, water and sanitation and education.

Delivering on the *Global Strategy* will require ambitious commitments from governments, businesses, academia, civil society and all sectors of society. Sustainable financing, strong accountability and national commitment are also critical; development must be transparent and aligned with national priorities.

EVERY WOMAN
EVERY CHILD

Technical Guidance for Prioritizing Adolescent Health

Acronyms

AA-HA!	Global Framework for Accelerated Action for the Health of Adolescents
ANC	Antenatal Care
ASRH	Adolescent Sexual and Reproductive Health
ART	Antiretroviral Therapy
CRVS	Civil Registration and Vital Statistics
CSE	Comprehensive Sexuality Education
DHS	Demographic Health Survey
EWEC	*Every Woman Every Child*
FGM/C	Female Genital Mutilation/Cutting
GFF	Global Financing Facility in support of *Every Woman Every Child*
GSHS	Global School-Based Student Health Survey
H6	Partnership between the 6 UN Health Agencies: UNAIDS, UNFPA, UNICEF, UN Women, the World Bank and WHO
HMIS	Health Management Information System
HPV	Human Papillomavirus
MICS	Multiple Indicator Cluster Survey
NCDs	Non-Communicable Diseases
NGO	Non-Governmental Organization
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SDGs	Sustainable Development Goals
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UN Women	United Nations Entity for Gender Equality and the Empowerment of Women
WHO	World Health Organization

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Part 1: Introduction

Adolescent health has become a priority on the global agenda. The *Every Woman Every Child Global Strategy for Women's, Children's, and Adolescents' Health* (2016-2030)[1], launched at the Sustainable Development Summit in September 2015, has added a focus on adolescents, in view of the uneven progress thus far in addressing their rights and needs. As part of the *Every Woman Every Child* movement, many governments have made political commitments to prioritize adolescent health together with their overall efforts in improving reproductive, maternal, newborn, child health. The H6 will be mobilizing its collective expertise and technical capacity to ensure adolescent health is addressed in country-led efforts to implement the *Global Strategy*, and will continue to advocate for evidence-informed reproductive, maternal, newborn, child and adolescent health (RMNCAH) programmes at all levels.

Most importantly, many low- and middle-income countries increasingly recognize the pivotal importance of addressing the health and development issues of their adolescent populations to reach the Sustainable Development Goals (SDGs) from now until 2030.

Beyond health itself, investments are needed in other domains crucial for an adolescent to survive, thrive and transform his or her society. In fact, success across the different SDGs — such as improving quality education, achieving gender equality and women's and girls' empowerment, promoting inclusive economic growth and decent work, reducing inequality within and among countries — will depend on the level and types of investments made in adolescents and their well-being, and the extent to which adolescents can make the most of the opportunities before them. By 2030, their life trajectory will be shaped by the actions and investments made today. Moreover, their experiences of engagement or of alienation, or their inclusion or further marginalization, can position or derail their efforts in driving the Sustainable Development era.

Given this context, this document can guide country stakeholders in conducting a systematic situation assessment that will enable them to prioritize adolescent health within their national policy processes. The goal is to ensure future investments are guided by available data on adolescents, and importantly, maximally-used to support evidence-informed health interventions that

1 http://globalstrategy.everywomaneverychild.org/

can be brought to scale in order to reach and fulfill the rights of adolescents, especially those left behind.

What is the purpose of this guidance document?

The purpose of this guidance document is to support national and sub-national stakeholders to both advocate for increased investments in adolescent health, and to help guide strategic choices and decision-making for such investments to be reflected in relevant national policies, strategies or plans (e.g., RMNCAH plans, adolescent health strategies, etc). This document can further guide a systematic process for ensuring adolescent health priorities are covered across the spectrum of actions required for adolescents to survive, thrive, and and bring about transformative change as envisioned through the *Global Strategy*, such as, for example, to guide the selection of priorities in the context of the Investment Cases of the Global Financing Facility in support of *Every Woman Every Child* (GFF). As this document focuses specifically on adolescent health, it can further be used in conjunction with broader tools and resources making investment cases for RMNCAH, including the *Operational Framework for the Global Strategy for Women's Children's, and Adolescents' Health*.[2] This technical guidance will further be complemented by the forthcoming *Global Framework for Accelerated Action for the Health of Adolescents (AA-HA!)*, which will aim to provide countries with a basis for developing a coherent national plan for the health of adolescents.[3]

Who is this guidance document intended for?

This document can be used by a range of stakeholders interested in adolescent health. The primary audience are the national and sub-national level decision makers in different government departments, as well as non-governmental organizations, civil society bodies or youth-led organizations, that work for — or contribute to — the health and development of adolescents. This includes a wide range of sectors including health, education, youth, women's affairs, and social protection. Furthermore, global and regional partners representing bilateral, multilateral, the private sector, development banks, research institutions, and think tanks who are supporting countries in their national-level prioritization processes could further maximize their collective engagement by utilizing this guidance.

How is this guidance document organized?

This document includes five main parts:

- Part 1 provides an overview of adolescent health on the global agenda, and explains the purpose and audiences of the guidance document.
- Part 2 briefly describes the rationale and arguments for why increased investments and prioritization in adolescent health and development is needed, as well as an overview of guiding principles.
- Part 3 describes a process by which to make strategic choices in priority areas of adolescent health. In particular, this section outlines key steps for carrying out a needs assessment and prioritization exercise that incorporates: (Step 1) a situation analysis on adolescent health and development, based on available country-level data; and (Step 2) a landscape analysis of existing policies and programmatic efforts underway. Following these steps, key issues and criteria are presented to guide the process for selecting adolescent health priorities (Step 3) and the key interventions to address them (Step 4). Part 3 also includes case studies of countries that illustrate the particular step. These countries have undertaken similar assessments which served as the basis for prioritizing adolescent health at the national level, or have incorporated adolescent health issues within national health plans.
- Part 4 concludes with a brief overview of next steps in tracking progress, including indicators (core and complementary indicators for the *Global Strategy*).
- Part 5 includes annexes with data sources, resources, and tools for the situation assessment and prioritization exercise. To support further advocacy efforts, a final annex articulates how adolescent and youth issues are critical in addressing the Sustainable Development Goals and select targets.

2 This resource, as well as many others, can be accessed at everywomaneverychild.org

3 http://www.who.int/maternal_child_adolescent/topics/adolescence/framework-accelerated-action/en/

Part 2:
Why invest in the health and development of adolescents?

A safe and successful passage from adolescence into adulthood is the right of every individual. This right can only be fulfilled if societies make focused investments and provide opportunities to ensure that adolescents progressively develop the knowledge, skills, social and economic assets, and resilience needed for a healthy, productive, and fulfilling life. Moreover, adolescence is a strategic period during the life course to emphasize empowerment and preventive approaches that would enable adolescents to survive, thrive, and transform their societies.

However, decisions made during adolescence, particularly regarding sexual and reproductive health, can have a long-term impact on the young person and on human development in general. Puberty—the biological onset of adolescence—brings not only changes to adolescent brains and bodies, but also new challenges and life transitions: initiating sexual activity, forming their identities, starting relationships, and in some cases, entering into unions and forming families, forced in the majority of cases. For many girls in particular, early adolescence marks the beginning of a life trajectory characterized by a lack of autonomy and choices in these areas, and vulnerabilities to human rights abuses. Girls across the world are often coerced into unwanted sex or marriage, and face high risks of unwanted pregnancies, unsafe abortions, and sexually-transmitted infections, including HIV. These challenges can have serious implications on other areas of their health, their education, their welfare, and future opportunities, as well as their countries' overall trajectory toward building inclusive and sustainable societies.

Beyond the specific and unique importance of sexual and reproductive health and rights during the second decade of life, there are sound human rights, public health, and socio-economic reasons for investing in the health and development of adolescents.[4]

First, adolescents have rights. Almost all countries are signatories to the *UN Convention on the Rights of the Child,* which clearly states that adolescents have many inalienable rights, including the right to be healthy. Therefore they have a right to obtain the information and health services they need to survive, grow, and develop to their full individual potential. Moreover, engaging adolescents in decisions

4 WHO (2014). *Health for the World's Adolescents: A second chance in the second decade*. WHO: Geneva.

affecting their lives builds their sense of agency and fosters inclusion. However, progress from current programmes has been uneven. Some programmes selectively benefit some adolescents, especially those living in advantageous situations, while many others have been left behind. This is especially true for those adolescents who are more likely than others to face rights violations and health challenges because social, economic, and cultural factors increase their vulnerability.

Second, there is a strong public health basis to directly prioritize and invest in adolescents. Globally each year, an estimated 1.4 million adolescents die from preventable causes, mainly due to road traffic injuries, violence, suicide, HIV and pregnancy-related complications. Investing in adolescents can also improve the health and well-being of many millions of adolescents who experience health challenges such as depression, anaemia, or HIV infection. Adolescence represents a critical life stage to promote the adoption of healthy behaviours for lifelong health. Laying that foundation helps prevent health-related problems that occur later in life, such as cardiovascular diseases resulting from physical inactivity, and lung cancer from tobacco use initiated during adolescence. Finally, investing in adolescent health can help avert problems for the next generation, such as prematurity and low birth weight in infants born to very young mothers. Prioritizing adolescent health simply is essential to end preventable deaths.

Third, there is growing recognition of the socio-economic benefits of investing in the healthy development of adolescents. Some countries have a proportionately large, young and working age population. With the right policies in place, healthy, educated and competent youth, who enter the workforce with the right skills, can help spur economic development of their country. Economists stress the importance of leveraging this "demographic dividend" for national development. Targeted investments particularly in the health and education of girls that enable them to delay marriage and childbearing could significantly increase their productive capacity, increase spacing between generations, and reshape and redistribute the dependency burden.

The converse is true: Not investing in the health and development of adolescents relates and contributes to the vicious cycle of ill-health and socioeconomic deprivation. Poverty and the lack of opportunities, as well as harmful gender norms, are at the core of why so many adolescents are forced into marriage or get pregnant, putting them at a disadvantage for their future socio-economic development, including their education and livelihoods.

What are our guiding principles?

Improving adolescent health and designing effective and appropriate interventions require adherence to a series of values and principles that encompass:

- Human rights, gender equality, inclusion and recognition of diversity
- Equity and reaching the most vulnerable adolescents
- Country leadership, transparency, and accountability
- Multi-sectoral approaches and meaningful partnerships
- Alignment with evidence-informed practices
- Adolescents' leadership, voice, and agency, including their safety and protection ("do no harm").[5]

These principles are embedded within the overall effort of *Every Woman Every Child*. Further, this guidance to prioritize adolescent health goes beyond a "disease-centric" model and emphasizes adolescents' human rights and their positive development – enabling them to not only survive, but also to thrive in and transform their communities across their life course.

5 This also involves respecting and supporting their evolving capacities (e.g., the "mature" adolescent) in relation to parental guidance and authority.

Part 3: The Needs Assessment and Prioritization Exercise – Making strategic choices for adolescent health and development

Steps required for a successful selection of priorities and interventions

Initiatives on adolescent health are being developed or are underway in many low- and middle-income countries. The adolescent groups targeted, the health challenges identified, the approaches used, and the organizations involved vary. Context matters, hence programme priorities on adolescent health should be drawn from a systematic needs assessment anchored in the available data and evidence.

For ownership and accountability, the government, usually the relevant line ministry at national level, should lead the needs assessment and priority setting exercise for adolescent health and development. In order to foster a culture of accountability and establish a commonality of purpose, all if not the most relevant ministries and departments can be brought together on one common platform or through an inter-ministerial coordination committee, presided over by a chair. Such a committee can play an oversight role, making decisions on programme implementation and budgetary allocation. A technical working group or advisory group should guide or inform the process, as well as develop the criteria and drive a transparent process for organizing the needs assessment and setting up consultations for the prioritization exercise.

In addition to the government, a range of stakeholders[6] should be involved in the process, especially adolescents and youth-led organizations. Their engagement will help shape potential programmes and policies to be relevant and appropriate, and to build the support necessary for success. These groups should be actively contributing to and engaged during key milestones for the assessment, for example, when a first analysis is completed.

The needs assessment includes the following steps that lead to identifying adolescent health priorities:

- Step 1 – Conduct a situation analysis on the adolescent health and development situation in a country or sub-region.
- Step 2 – Conduct a landscape analysis to review the current programmes and policies underway to address the situation.

6 In addition to adolescents and youth-led organization, a list of key stakeholders such as families, civil society groups, teachers, etc. are noted in a subsequent section.

- Steps 3 – Based on the results of the analysis conducted in steps 1 and 2, identify the adolescent health priorities based on clear criteria.

- Step 4 – Define a strategy of interventions and the delivery mechanisms to address the health priorities and gaps identified through the assessment.

These four steps are described in further detail in the following sections.

Step 1: Conduct a situation analysis on the current adolescent health and development situation

What is a situation analysis? What should it cover?

The situation analysis is a systematic method for reviewing the overall context, health status, and well-being of adolescents in the country or sub-region. It also identifies priority health issues specific to subgroups of adolescents. The situational assessment uses available data to identify the adolescents facing the greatest need for services and other programmes, including education, life skills, and social protection.

The situation analysis should examine the following issues:

- The main health challenges affecting adolescents and the contexts in which they take place

- Harmful practices affecting adolescents (e.g., levels of child marriage, female genital mutilation, etc.

- The socio-cultural context of their lives, including the protective and risk factors at various levels (e.g., individual, family, peer, community, etc.) and with institutions (e.g., schools, health services, employment, etc.) that can influence their health

- The behaviours that are likely to be linked to some health conditions or that could lead to and result in health problems in the future (e.g., risk factors including tobacco consumption, poor nutrition, etc.).

The situation analysis should take into account that adolescents are a very heterogeneous group, yet often this diversity is masked when only national aggregate figures are used. Therefore, the situation analysis should gather data that can be disaggregated by sex, age subgroups (e.g., 10-14 and 15-19 year olds), education level or schooling status, literacy level, marital status, household wealth, location (e.g., urban vs. rural), and living arrangements (e.g., living in a single-parent household), when possible. Depending on the context, other domains will be relevant (e.g., ethnicity, sexual orientation, and gender identity).

However, in some countries, the available data still will not do justice in presenting the diverse circumstances of their lives for different reasons. For example, the data may be lacking (e.g., in humanitarian settings), or more generally, the quality of the data may be inadequate.[7] While countries indeed need to invest in stronger data systems, it is important to still mine, utilize, and analyse any existing data to describe the diverse situations found among adolescents, recognizing these limitations. In collecting such data, care must be taken to do so with strict ethical standards. Information provided by data could also be complemented with qualitative information.

Why conduct a situation analysis?

First, the situation analysis will construct a picture of adolescents' current situation, including their health, thereby providing the starting point for appropriate programmatic and policy responses. It will also help identify those adolescents with the greatest needs, and also which needs are identified by adolescents themselves as being high priority. This will help ensure the right issues and the right subgroups of adolescents are addressed. Second, the situation analysis will identify gaps in the data and evidence. This will point to where additional work is needed, such as to gather or analyse specific information through research. Finally, if all the relevant stakeholders are involved, this will contribute to and help ensure a shared sense of what action and research steps are needed and for which subgroups of adolescents most in need.

Who should lead and be involved?

The situation analysis should be done by individuals with expertise in adolescent health and development issues, as

7 Annex A describes various data resources (primary sources and secondary analyses) noting some limitations specific to adolescents as well as specific subgroups, for whom different approaches and analyses will be needed.

BOX 1: Case Example of Situation Analysis – Ethiopia's National Adolescent and Youth Health Strategic Plan (2016-2020)

Ethiopia's National Adolescent and Youth Health Strategic Plan for 2016-2020 sets out the priority health needs and challenges facing adolescents and youth in the country. It also takes stock of the adolescent health situation, drawing principally from Ethiopia's 2011 Demographic Health Survey (DHS).

Facts summarized in the Situation Analysis:

Sexual Activity: In Ethiopia, sexual activity for girls and young women is primarily in the context of marriage. 26 and 64 per cent of ever-married young women had sexual intercourse before age 15 and 18, respectively, compared with less than 1 per cent and 3 per cent, respectively, of never-married women. Ever-married young men are more likely than never-married men to have had sexual intercourse before age 18, but still at lower proportions compared to ever-married young women (30 per cent compared to 64 per cent). The median age at first sexual intercourse for women age 25-49 years was 16.6 years, about a year higher than the result of Ethiopia DHS 2005 (15.7 years).

Child Marriage and Early Pregnancy: According to UNFPA's 2012 report on child marriage, in Ethiopia, about one in five girls (20 per cent) marries before the age of 15 and two in every five girls (40 per cent) marry before their 18th birthday. The poorest, least educated girls living in rural areas are most affected. 22 per cent of rural girls ages 15-19 are married, compared to 8.1 per cent of urban girls. In some regions, the prevalence of child marriage is higher than the national average. For example, in Amhara, over 50 per cent of young women (20-24 year olds) are married by age 18. Child marriage in Ethiopia often marks the beginning of sexual activity and early and frequent childbearing. Since the 2000 DHS, the proportion of adolescent girls (ages 15-19) who are already mothers or pregnant with their first child, has declined from 16 per cent (DHS 2005) to 12 per cent (DHS 2011).

Unsafe Abortion: Routine monitoring of the magnitude of abortion and related morbidity and mortality is poor in Ethiopia. But anecdotal reports suggest that it is high.

HIV: The 2011 Ethiopia DHS showed that the prevalence of HIV among young people in Ethiopia is relatively low (<1 per cent). However, disparities exist between young females and males. HIV prevalence was 0.1 per cent among 15-19 year olds (0.2 per cent among females and 0 per cent among males), 0.6 per cent among 20-24 year olds (0.9 per cent among females and 0.2 per cent among males), and 2 per cent among 25-29 year olds (2.9 per cent among females vs. 2 per cent among males).

Malnutrition: Deficiencies in iron (anemia), vitamin A, and iodine primarily affect children (<5 years) and pregnant and lactating women. Findings from the 2011 Ethiopia DHS indicate that as many as 13 per cent of girls and 18 per cent of boys in the 15-19 age group are anemic. Moreover, in the same age group, nearly two-fifths of the girls (36 per cent) and two-thirds of the boys (66 per cent) are very thin (BMI<18.5kg/m^2).

Substance Use: The most common addictive substances used by adolescents and youth in Ethiopia are cigarettes, alcohol, and khat. As reported by the 2011 Ethiopia DHS, cigarette smoking is widely practiced by male adolescents and youth with the prevalence of 4.4 per cent. The 2011 Ethiopia DHS also indicated that nearly half (45.6 per cent) of Ethiopian adolescents and youth consume alcohol more than six times in a month.

Mental Health Problems: Mental problems related to alcohol and substance use, schizophrenia, seizure disorder and bipolar disorder affect an estimated 0.5 to 1.5 per cent of the Ethiopian population (Ministry of Health, 2015).

Non-Communicable Diseases (NCDs): According to the WHO, NCDs are estimated to account for 34 per cent of all deaths in Ethiopia across all age groups in 2001. Fifteen per cent of these deaths are accounted for cardiovascular diseases, 4 per cent for cancers, and 4 per cent for respiratory diseases. Nationally-representative surveys or studies on the prevalence of NCDs and their risk factors are not available.

Road Traffic Injuries: According to WHO, 2,581 road traffic fatalities were reported in Ethiopia in 2013 with 377,943 registered vehicles (Global Road Safety Report, WHO, 2013).

Gender-Based Violence. In the 2005 Ethiopia DHS, 81 per cent of married women agreed that a husband beating his wife is justified. This decreased slightly in the 2011 Ethiopia DHS (68 per cent).

Female Genital Mutilation: In the 2005 Ethiopian DHS, the prevalence of FGM/C in girls and women (15-49 years) was 74.3 per cent. This represented a 5.6 per cent decline from 79.9 per cent in the 2000 Ethiopian DHS.

Source: *Federal Democratic Republic of Ethiopia, Ministry of Health/Maternal and Child Health Directorate. National Adolescent and Youth Health Strategic Plan (2016-2020).*

well as in research methods. A team can be drawn from the government, non-governmental organizations (NGOs), youth-led networks (particularly individuals who know and come from communities and sub-national areas with greatest needs), academic institutions and development partners. Adolescents too could and should meaningfully contribute to the needs assessment. To the extent possible, an assessment team would benefit from having members with complementary skills sets, including young researchers, data analysts or activists who can bring the interdisciplinary perspectives crucial for addressing adolescent health. Working and consulting with key stakeholders across sectors ensure that the situation assessment is both well-informed and builds support for future efforts.

Key stakeholders include:

- Governmental officials at various levels (national, provincial, regional), both within the Ministry of Health, but also in other ministries including those responsible for education, youth, sports, social development, and employment, as well as in the Ministry of Finance
- Civil society representing the diverse range of interests among adolescents (e.g., education, health, livelihoods and employment, social protection, etc.), as well as professional associations
- H6 technical organizations (UNFPA, UNICEF, UNAIDS, UN Women, World Bank, WHO)
- Bilateral and donor organizations, as well as public and private health insurers that can help finance the delivery of health programmes
- Adolescents and youth, including youth-led networks and organizations
- Families, including parents
- Community members that have direct contact with adolescents, including health care providers, teachers, mentors, sports coaches, etc.

How to conduct a situation assessment?

A situation assessment could consist of a desk review (e.g., of available national and sub-national studies, peer-reviewed articles, other common country assessments, data from health, education and other management information systems etc.), a secondary analysis of existing country-level data, and consultations with key stakeholders, as previously mentioned. If needed, this can be supplemented with focused information gathering and analysis. If information is gathered from adolescents themselves, such efforts should be guided by ethical principles and practices so as to avoid any potential harm to the participants.

Annex A contains a list of existing data sources, such as the Demographic Health Surveys (DHS), Multiple Cluster Indicator Surveys (MICS), national disease surveillance records, national vital statistics, and educational records. The annex also contains an annotated list of resources and tools that can be used to carry out a rapid needs assessment.

Step 2: Conduct a landscape analysis to review existing adolescent programmes and policies

What is a landscape analysis?

A landscape analysis should identify and map existing programmes, policies, and projects that address adolescent health and development by geographic area, the socio-demographic characteristics of the beneficiaries, as well as the results and outcomes from these programmes. Second, it should identify the stakeholders and organizations involved in planning, managing, implementing, monitoring and evaluating these activities, at the national and sub-national level. It should also identify the systems that are in place to support capacity development, supportive supervision, coordination, and other planning and management functions. Crucially, it should examine how adolescents and youth participate in and contribute to these efforts, and the systems or platforms in place for them to do so. Thirdly, it should seek to identify existing and potential sources of financing (domestic and international) and current budgetary allocations, especially how they meet the required needs.

What topics should it cover?

Illustrative topics that should be addressed in a landscape analysis include:

- Existing health policies, programmes, and interventions that address adolescent health, and the specific health services defined for adolescents, including the geographic reach.

- The extent to which interventions address the differentiated needs of diverse subgroups (e.g., segmented by age, sex, and other socio-demographic variables)
- The technical integrity of the interventions and evidence to their impact
- Scale and scope of these programmes
- Coverage of the programmes (e.g., who is currently being reached, and where? Who is being left out?)
- Achievements and results from the programmes (e.g., from evaluations)
- Service gaps and quality issues
- Challenges to implementation

- Other sectoral programmes (e.g., education, social protection, etc.) that would have an impact on adolescent health
  - Any areas of unnecessary duplication or overlap of programmes within and across the sectors being examined

- Funding levels
  - The total funding, including the distributions of resources across sectors and interventions
  - Proportion of domestic resources vs. external resources to support the current programmes and projects
  - Resource gaps

Why conduct a landscape analysis?

First, the landscape analysis provides the current picture of efforts to meet the needs and fulfill the rights of adolescents, the results and achievements of such efforts thus far, the key stakeholders involved, the systems in place, and the financial resources to support these programmes and activities. The landscape analysis would also point to the areas of strengths and weaknesses within these programmes, and what could be done to build on the current situation.

Second, by specifically addressing adolescents as a priority population, the landscape analysis also fills important knowledge gaps. Adolescents have typically straddled a space between "children" and "adults". Most investments and programmes on children focused on the first decade of life, while adult programmes would not be appropriate to adolescents. "Youth" programmes often skew toward older ages and likely will not capture adolescents' developmental needs. Consequently, there are fewer experiences in implementing and evaluating programmes geared for adolescents. The body of evidence on what types of programmes and interventions work best for this age group still requires careful review and analysis.

Crucially, adolescent health programmes must involve multiple interventions delivered through various sectors beyond the health sector. Gendered expectations and norms significantly create further pressures on adolescent girls and boys, necessitating work across sectors and with diverse actors to promote positive health and development outcomes.

Who should lead and be involved?

The landscape analysis should be done by individuals with expertise in adolescent health and development issues, and with analytical writing skills and experience in research methods. It should involve an interdisciplinary team drawn from the government, civil society, youth-led organizations, and academic institutions. Moreover, adolescents themselves should be meaningfully engaged for an authentic process. Ethical considerations and issues around informed consent will also require innovative ways to capture their honest voices and diverse perspectives, and not only through "adult filters".

How to conduct a landscape analysis?

This exercise should consist of a desk review of relevant policies and strategies, as well as plans and reports of relevant programmes and projects. In the absence of any dedicated programmes for adolescents, the landscape analysis would need to examine any potential overlaps within existing children's health programmes or those geared for youth or adults. Such a scenario is common but presents an opportunity to document and highlight existing gaps and needs.

If resources (financial and human) and time allow, the landscape analysis would be further enriched with field visits, coverage studies of the reach of existing programmes and services, as well as key informant interviews. Key informants can further explain existing programme challenges and successes, perceptions of needs and services, and the opportunities and capacity for expanded work on adolescent health.

The results from the data stock-taking (step 1) and landscape analysis (step 2) would inform and feed into the prioritization process (step 3).

BOX 2: Case Example of Landscape Analysis – Mongolia's Rapid Programme Review on Adolescent Health

In 2011, the Ministry of Health of Mongolia, with support from WHO, reviewed progress in the country's adolescent health work.

The first step was to agree on the objectives, scope, and methods of the review.

The second step was to constitute a team, which included the Ministries of Health and Education, UN agencies, and technical experts within the country and from Australia.

The team gathered and analysed all the relevant data including policies, plans and reports of the HIV, reproductive health, mental health, nutrition, tobacco and alcohol programmes of the Ministry of Health. They conducted field visits to health facilities. Consultations and key informant interviews were done with programme managers and service providers from the health and education sectors in the capital city and from three provinces ("aimags"), as well as adolescents, international NGOs and other UN agencies.

The team then made **a short list of recommendations** (below) grounded in the national health plan and WHO's country cooperation strategy, and outlined next steps in implementing and monitoring them:

- Fill the gaps in adolescent epidemiology, identified in this review.
- Step up the implementation of the actions proposed in the strategies in all areas reviewed. In doing this, make every effort to strengthen synergies and use available assets effectively and efficiently (e.g. use a training opportunity for one health area to build capacity in others as well).
- Document, evaluate, and disseminate the experiences gained in youth-friendly health service provision in the country.
- Integrate and scale up youth-friendly initiatives within the existing primary health care system (including *soum* health facilities, family group practices and *bag feldshers*).
- Strengthen coordination and collaboration within the Ministry of Health, and with other sectors to ensure that a truly multisectoral response is in place. This may be achieved by establishing mechanisms such as a task force and a designated official/unit responsible for adolescent health.

Specific recommendations were made with respect to two areas:

1. Mental Health:

- Strategic information: Identify appropriate indicators on adolescent mental health, and ensure that age and sex disaggregated data is gathered, analysed and used.
- Supportive policies: The policies in place are sound. The challenge is applying them.
- Services and commodities: Build the capacity of primary level health workers to diagnose and manage mental health issues at the primary level, and to refer patients who need specialized care to the next level.
- Strengthen other sectors:
  - Build the capacities of teachers to build the psychosocial skills in their students, and to identify and refer those students who have mental health issues that might need medical attention.
  - Build the capacities of parents to build the psychosocial skills of their sons and daughters and to refer them for medical attention if they might need it.
  - Create awareness in communities about the need to promote mental health and respond to mental health issues when they occur with empathy and understanding.

2. Sexual and reproductive health including HIV/STIs

- Strategic information: Strengthen epidemiology of STIs in young people.
- Supportive policies: The policies in place are sound. The challenge is applying them.
- Services and commodities:
  - Draw out the lessons learned from the adolescent-friendly health services in the country.
  - Scale up "friendly" health service provision to adolescents using the existing health care delivery system.
- Strengthening other sectors: Build the capacities of teachers to carry out effective reproductive health and life skills education programmes.

Key success factors for the assessment:

- Significant government leadership and ownership. The Ministry of Health was fully behind this effort; it engaged and assured the involvement of other sectors. It also assured that the conclusions and recommendations of the review were shared and discussed with senior officials from all the others.
- Support through the UN System. Key agencies worked together to carry out the review and support the government and partners.
- A systematic approach guided the process. The step-by-step approach used to plan and execute the review involved literature reviews, key informant interviews, field visits and a meeting to bring the threads together.

Source: *WHO WPR/DHP/MCN(1)/2010.1, Report series number: RS/2010/GE/__(MOG)*

Step 3: Define the priority adolescent health areas to focus efforts

What is a prioritization process?

The prioritization process is a systematic approach that uses a clear set of criteria to determine which of the many needs of adolescents to be addressed, and which specific adolescent populations require special focus within future efforts.

This priority setting process builds on the earlier two steps: (1) the situation analysis, which identified the needs of adolescents across a range of issues, as well as specific groups of adolescents who are more likely to face health and social challenges and are least likely to be reached by programmes; and (2) the landscape analysis, which identified the strengths and gaps of the current policy and programmatic response.

Why conduct a prioritization process?

Adolescents have many diverse needs. All countries, but especially those with the greatest resource constraints, will need to make difficult choices so that they can address a selected number of needs, paying particular attention to those adolescents whose rights to survival and health are most undermined.

Who should lead and be involved?

The priority setting exercise should be led by individuals with expertise in adolescent health and development issues, including public health, with a clear understanding of the country context. Costing expertise is also essential.

The Ministry of Health and partners can designate a team drawn from other ministries, civil society, and academic institutions to lead the prioritization process. Adolescents themselves, as well as organizations that they represent or are active in, should continue their ongoing engagement.

Determinants of adolescent health are diverse, and many lie outside of the health sector. To achieve improved adolescent health outcomes, other relevant ministries and sectors (e.g., women and children's affairs, education, labor, social protection, etc.) must be engaged to contribute to a multi-sectoral response. The health sector needs to make its own contribution, including technical support and coherence, as well as disseminate epidemiological information. It can also facilitate the complementary actions of other sectors to adolescent health and development.

How to prioritize the adolescent health issues to address?

Difficult decisions will need to be made on a number of issues, including what to do and what not to do, and where to invest available resources. While recognizing there will be many competing factors, this process should be transparent and consultative, and based on clearly defined and agreed upon criteria.

A clear set of criteria includes:

- *Magnitude of the issue*: Resources should be directed first toward addressing the main causes of death, illness, and injury, and the behaviours of adolescents or others that contribute to these factors, now and in the future.

- *Groups of adolescents most affected*: All adolescents have health-related needs and can experience problems, but not all are equally vulnerable. Some subgroups are more vulnerable to health and social challenges than others. Some adolescents have overlapping vulnerabilities that make them particularly at risk of the worst health outcomes (e.g., they are out-of-school, coming from the poorest households, living in communities with high rates of child marriage and early and frequent childbearing, etc.). Efforts to reach all adolescents should be balanced with efforts to reach specific vulnerable groups.

- *Availability of effective interventions*: It is important that scarce resources are used to deliver interventions that have the highest chance of being effective. The proposed interventions should be guided by the strongest available evidence, recognizing that research is underway to identify the most effective interventions and ways to deliver them.

- *Feasibility of delivering interventions*: Social, economic, and cultural constraints, including the lack of recognizing adolescents' rights, may make it difficult to deliver certain interventions. Priority setting must be based on a careful and pragmatic analysis of the feasibility to implement and deliver the interventions with fidelity and at scale.

- *Potential to go to scale*: An assessment of the current and needed capacity to deliver the interventions will be required. Strong government ownership and political will help drive expansion. Costing exercises can inform overall resource needs, and how plans can be implemented in a phased approach.

BOX 3: Case Example of Prioritizing Adolescent Health – India's Rashtriya Kishor Swasthya Karyakram (RKSK)

Recognizing the potential of investing in adolescents for a demographic dividend, the Government of India in 2014 launched "Rashtriya Kishor Swasthya Karyakram" (RKSK), a national strategy that proposes a multi-level, multi-sectoral solution to enhance adolescent health. Based on the principles of participation, rights, inclusion, gender equity and strategic partnerships, RKSK takes a comprehensive approach to adolescent health and well-being and situates adolescence in a life-course perspective within dynamic sociological, cultural and economic realities. While building linkages to a wider RMNCAH agenda through the continuum of care and health systems strengthening approaches, RKSK represents a shift from a clinical approach to an effective community-based health promotion and preventative care.

In 2013, the Government of India and UNFPA shepherded a multi-sector process with relevant line ministries (e.g., Health, Youth, Education, Women and Children, etc.) to develop a holistic adolescent health programme that goes beyond clinical services. The process engaged young people from diverse backgrounds to share their needs and concerns from existing programmes, and proposed solutions to address the gaps. The Ministry of Health and Family Welfare, supported by UNFPA, worked with leading NGOs and young people to develop detailed implementation plans for the strategy's launch and rollout.

The strategy prioritizes six areas of adolescent health that were identified through a situation analysis: nutrition; sexual and reproductive health; mental health; injuries and violence; substance misuse; and non-communicable diseases. The interventions are planned at distinct layers in the adolescent's environment: individual, family, school, and community, thus entailing integrated action of different sectors. Though the strategy is within the Ministry of Health and Family Welfare, the engagement of other sectors is ensured through multi-sectoral steering committees that operate on national, state, district and village levels. One innovation to increase accountability was to involve adolescents themselves in participatory monitoring. This monitoring mechanism is also complementing data gaps in the health management information systems (HMIS) which has limited age-disaggregated, adolescent-specific data.

Source: *UNFPA Case Study on India's RKSK and the Every Women Every Child Operational Framework*

BOX 4: Case Example of Ensuring Adolescent Health is Part of Universal Health Coverage – Argentina's Programa Sumar

To respond to the poor maternal and child health outcomes exacerbated by an economic crisis, in 2004 Argentina launched a national programme, Plan Nacer, in order to ensure key health services for pregnant women and children under age six without formal insurance. By applying results-based financing approaches to improve coverage and service delivery, Plan Nacer increased the use and quality of ante-natal services and improved birth outcomes. Building on these successes, Plan Nacer evolved into Programa Sumar, which in 2012 expanded coverage to more age groups such as children ages 6-10 years, adolescents ages 10-19 years, and adults up to 64 years old, offering more than 700 health benefits.

For adolescents, Programa Sumar provides general health check-ups and referrals to specialists; nutrition information and counseling; sexual and reproductive health services, including confidential sexual health counseling, pregnancy testing and diagnosis, and contraceptive information and services; immunizations; mental health consultations; dental and ophthalmological check-ups; and urgent care related to suicide attempts and sexual violence. Workshops about health promotion specifically for adolescents are conducted in different settings. The programme guarantees more than 50 health services for adolescents, with a coverage of 96 per cent of eligible adolescents (2.9 million) enrolled. Pregnant adolescents also benefit from the pregnancy allowance coverage and monitoring activities. Among the enrolled pregnant women, approximately 11 per cent are adolescents.

Moreover, quality standards for adolescent health have been defined jointly with the National Programme for Adolescent Health, National Mental Health Programme, and the Sexual Health Programme. Confidentiality and privacy at the services are also ensured.

Programa Sumar employs an innovative results-based financing (RBF) scheme that emphasizes a strong working relationship between the federal and provincial governments, capitalizing on the existing decentralized health system where the provinces maintain autonomy in decision-making and operations. By integrating health insurance and result-based financing, Programa Sumar employs two types of incentives. First, the Ministry of Health provides provincial governments with capitation payments based on the number of beneficiaries enrolled and tracer indicators achieved. Secondly, health facilities are incentivized by the provincial governments according to the number of services provided that meet quality standards. With autonomy to invest the funds as they see fit, health facilities have used them to improve infrastructure and service delivery or paid bonuses to health workers.

In Argentina, results-based financing strengthened the national and provincial leadership and accountability, and reoriented the management and care model within the health system. Data management also enhanced performance and helped to set clear goals for service provision. A key lesson learned was to ensure the autonomy of health facilities to use incentives while providing facilities with adequate guidance for investment.

Plan Nacer and Programa Sumar have helped Argentina to effectively tackle health inequalities. The use and quality of antenatal care services has increased, and neonatal deaths and low birth weight have reduced among the poorest populations. Health coverage for other age groups such as adolescents has expanded.

Source: *Plan Nacer and Programa Sumar: Moving Forward toward Effective Universal Health Coverage; Health Results Innovation Trust Fund. 2014. RBF. A Smarter Approach to Delivering More and Better Reproductive, Maternal, Newborn and Child Health Services. World Bank Group*

Step 4: Define a strategy of interventions to address the adolescent health priorities and determine the mechanisms to deliver them

What is a strategy of interventions?

This step in the process involves making choices about interventions and delivery mechanisms. It is based on a sound understanding of the local context and available evidence on the effectiveness of interventions and delivery mechanisms.

Why a specific strategy of interventions?

An effective strategy to promote adolescents' healthy development and prevent and respond to their health problems requires a package of interventions that addresses contextually-relevant factors that contribute to their poor health. The interventions themselves should be both evidence-based and feasible to deliver. Another important component is to have clear mechanisms to implement these interventions, given the social, economic and cultural context, and the platforms to deliver them.

Who should lead and be involved?

A strategy that contains tailor-made set of interventions and delivery mechanisms should be led by individuals with a sound understanding of effective interventions and their delivery mechanisms. Ideally, such individuals should have expertise in adolescent health and development, in public health, and in strategy development.

Because the choice of interventions and delivery mechanisms will need to be tailored to the local context, the strategy development process must be done with the full involvement of stakeholders who know and understand the local context, the scientific evidence, and available resources. Again, adolescents themselves, and organizations that they work for or represent them, should be meaningfully engaged in the process.

How to define the strategy?

The strategy development should be done using an iterative decision making-process.

For each health outcome to be achieved, identify the following:

- The adolescent actions and behaviours that most directly contribute to the health outcome
- The factors that influence the actions and behaviours
- The interventions to address these factors (that would be feasible to do and would build on what is being done)
- The indicators and means of verification (that would be feasible to do and would build on what is being done).

Once this is done, practical considerations in planning and managing the delivery of the intervention package, as well as the costs of doing so, will need to be carefully considered.

A body of evidence about what works and does not work for adolescent sexual and reproductive health in particular is increasingly emerging.[8] Yet ineffective interventions and approaches continue to be implemented, while effective interventions are delivered ineffectively. For example, comprehensive sexuality education (CSE), when delivered according to standards and evaluated practices, has been proven effective in increasing knowledge, clarifying values and attitudes, increasing skills, and impacting self-reported behaviours. However, in many cases, curricula are often weak or lacking key content, teachers are uncomfortable with delivering the content, or little or no linkages to health services exist. Moreover, other platforms for CSE delivery beyond schools may also be needed when large proportions of adolescents are not in school. Consequently, the intended outcomes among adolescents are not realized.

Key overarching recommendations toward selecting interventions to address adolescent health priorities include:

- Avoid approaches that while popular may not be effective.
- Tailor interventions according to the priority adolescent subgroups and their specific contexts (one size does not fit all).
- Determine the best delivery mechanisms to deliver interventions according to the fidelity of the model (including dosage and intensity needed for effectiveness), and avoid piece-meal approaches (shortcuts rarely work).
- Have a clear logic model linking interventions to influencing determinants, results, and outcomes.
- Build in an evaluation and learning agenda by rigorously documenting progress and utilize different methodologies to monitor and evaluate the interventions.

8 The Global AA-HA! Framework will also aim to summarize the evidence-based interventions across all major health conditions.

BOX 5: Case Example of Selecting Interventions to Address Adolescent Health Priorities – Liberia's Investment Case

Liberia is among the "second wave" of countries supported by the Global Financing Facility in support of *Every Woman Every Child* (GFF) to strengthen its health system and improve the delivery of RMNCAH services. In 2016, the Ministry of Health developed its RMNCAH Investment Case in close collaboration with development partners such as WHO, UNFPA, and the World Bank. The Government wanted to strengthen the adolescent component within the existing Investment Case by selecting a few focused adolescent health priorities and outlining the specific interventions to address these priorities.

A technical team involving the Ministry of Health, WHO, UNFPA, and the World Bank followed a systematic process to strengthen the adolescent focus in the country's RMNCAH Investment Case. The below describes the key steps taken.

Step 1 - Identify the priority health problems to address.

Building on the data provided in the Investment Case, Liberia selected the following four adolescent health problems to prioritize: (1) pregnancy-related mortality and morbidity, and rapid-repeat pregnancy; (2) unsafe abortion and mortality from unsafe abortion; (3) early and unintended pregnancy and STIs, including HIV; and (4) gender-based violence, including FGM/C.

Step 2 - Use a logic framework to identify the expected health outcomes, the related adolescent behaviours, the contributing factors to the behaviours, and the interventions to address them.

For example, to address the first adolescent health priority (prevent mortality and morbidity during pregnancy, childbirth, and the post-partum period), the team recognized that pregnant girls commonly access antenatal care late during their pregnancy, and they do not seek timely care when danger signs arise. At the individual level, this could be due to not knowing the importance of antenatal (ANC) visits, or to being treated poorly at the services. Health care workers may hold judgmental attitudes toward pregnant adolescents, or lack guidance on how to better serve them.

The team identified the following interventions to address the above behaviours and factors:

- At the systems and community level: (1) expand access to skilled ANC, childbirth, and post-natal care; (2) actively promote post-partum family planning; and (3) increase community awareness and support to pregnant adolescents to be prepared for childbirth, including any emergencies.
- At the individual girl level: (1) inform adolescents about the importance of ANC, childbirth and post-partum care; and (2) ensure health care workers are responsive to the special needs of the youngest, first-time mothers.

The team recommended the following indicators and means of verification to track progress:

- Number of adolescents who die of pregnancy-related causes
- Number of adolescents who obtain ANC and skilled delivery of care
- Proportion of pregnant adolescents who have developed birthing plans.

Step 3 - Identify the activity items and the modus operandi for carrying them out.

The team then detailed out specific activities to cover the four health priorities above and discussed costing with the assumptions. Activities were also clustered according to actions that would benefit the general population (e.g., systems-level strengthening that improves access and quality to the services, social norms change, etc.), as well as those specifically for adolescent populations.

Activity items geared for adolescents included:

- Implementing school-based education programmes. The County Education Office will procure teaching materials. Teachers deliver the programme, and will be trained and supported on a regular basis by the County Education Office and an international NGO (and/or academic unit).
- Carrying out community-based education and empowerment programmes for adolescents. The Country Education Office and Youth Coordinator will procure educational materials and supplies. A local civil society organization will deliver the programme, and will be supported by the community health department, youth coordinator, and an international NGO (and/or academic institution).
- Making health services adolescent-friendly, which means ensuring privacy and confidentiality, respectful and non-judgment treatment, and delivered free of violence and discrimination. The County Health Team will procure materials, train and support health care providers on a regular basis, and monitor the quality of the health services to be not only equitable and accessible, but also acceptable, appropriate, and effective for adolescents.

Activity items for the population as a whole included:

- Strengthening health service provision for all segments of the population.
- Carrying out community awareness activities in support of adolescents on topics such as birth preparedness for adolescents, unsafe abortion, sexuality education, sexual and reproductive health services, and gender-based violence.

Source: *Chandra-Mouli, V. (2016). From the technical assistance mission of July 2016 to strengthen the adolescent focus within Liberia's RMNCAH Investment Case (GFF). Detailed plan available upon request*

BOX 6: Case Example in Developing a National Adolescent Health Strategy – Bangladesh

Bangladesh had a National Adolescent Reproductive Health (ARH) strategy in 2006 and an action plan developed in late 2013. Two major operational projects on maternal, newborn, child and adolescent health under the ongoing Health, Population, Nutrition Sector Development Program (HPNSDP, 2011-16) planned to carry out selected health activities from the ARH strategy. However, most public health facilities lack appropriate and friendly services for adolescents. Some NGOs implement their own adolescent friendly services in dedicated clinics. There are no standard operating procedures (SOPs) on adolescent health with indicators on quality of care, and the HMIS does not adequately track services rendered to adolescents.

Recognizing these needs and challenges, the Government of Bangladesh wanted to advance gender-responsive adolescent health outcomes by focusing on the specific needs, transitions, relationships, and vulnerabilities that adolescents experience during this important time in their lives, while also fostering self-awareness, autonomy, and agency.

Key partners included:

- Government: Ministry of Health and Family Affairs (Directorate General of Family Planning and Directorate General of Health), Ministry of Local Government, Ministry of Education, Ministry of Women and Children's Affairs, Ministry of Youth and Sports
- UN Agencies: UNICEF, UNFPA and WHO.

Country Achievements (2014-2016) include:

- Development of the Comprehensive Adolescent Health Strategy (CAHS), a leading policy document based on the ASRH strategy (2006). Key partners are in the process of developing the new strategies focusing on adolescent sexual and reproductive health, physical health, nutrition, mental health and risky behaviours.
- Prioritized Adolescent Health in the Strategic Investment Plan of the 4th Health, Population and Sector Development Programme (2016-2021) and results framework.
- The human papillomavirus (HPV) demonstration programme launched in April 2016. Selected adolescent health messages have been integrated in the HPV training and service delivery strategy.
- An adolescent health assessment in health facilities was conducted to provide baseline information and to plan effective interventions for adolescents at government and non-governmental health care facilities.

The other priorities include:

- Integrating adolescent health in the health management information system (HMIS). This will help to integrate critical adolescent health variables in the existing HMIS. Collection, analysis, and use of sex- and age-disaggregated data will be done which will be used to advance the evidence base on structural determinants and gender norms in shaping adolescent health outcomes.
- Strengthening health systems to better meet the differentiated needs of girls and boys. Since children often fall off the routine health service delivery mechanisms during the second decade of life, maximizing opportunities to deliver integrated services for multiple purposes through existing delivery platforms will be considered. Adolescent health will be integrated within existing maternal, newborn, children and nutrition programmes.
- Creating demand to address the underlying gender norms and inequalities in adolescent health risks. Fostering demand for services for adolescent will be undertaken through existing community groups under clinics formed by the Ministry of Health and Family Welfare. Non-health sector interventions will create awareness, education, and communication initiatives to support social movements against child marriage, access to health service by adolescents, water, sanitation and hygiene (WASH) including menstrual hygiene management in schools, and adolescent clubs.

Source: *UNICEF Bangladesh country case study*

Part 4: Next Steps for Consideration

Tracking Progress

A monitoring framework for tracking progress toward implementing the *Global Strategy for Women's, Children's and Adolescents' Health* has been developed. The framework builds on a consultative process to identify core and complementary indicators covering the focal population subgroups across the three key pillars: survive, thrive, and transform. A main goal in selecting indicators was to harmonize with ongoing monitoring efforts at the global level while minimizing country reporting burdens.

These indicators, which align well with those for the SDGs, are represented in the following tables from *Indicator and Monitoring Framework for the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030).*

- Table 1 presents the full set of 60 indicators as a technical resource for monitoring the *Global Strategy*, organized by the three *Global Strategy* axes and divided into two groups: (1) the proposed indicators for the 17 targets that are central to the *Global Strategy*; and (2) those that are a priority for the *Global Strategy* but not proposed for the SDG process. The adolescent-specific ones (age-disaggregated) are highlighted in red, while general indicators that are also important and include adolescents (but not age-segmented for 10-19 year olds) are highlighted in blue.

- Table 2 maps each indicator, by target, to the population or populations covered in order to illuminate the depth and breadth of coverage across these focal populations. It also notes where age-disaggregation is recommended.

Where appropriate, the use of performance indicators (e.g., tracers and outputs) can be incorporated in order to track adolescents' access to the prioritized interventions defined in the essential health package. For example, adolescent-specific tracers could include an annual check-up and follow-up for 10-19 year olds, as well as ANC visits and delivery for pregnant adolescents.

BOX 7: Missing the Mark for 10-14 Year Olds

A commonly-identified data gap is the lack of indicators related to 10-14 year old adolescents, particularly girls. Many current mechanisms begin measurements on reproductive health at age 15, rendering invisible the experiences of younger adolescents who are in need of health services, such as those who may be sexually-active or menstruating for example. Programmes may also overlook this particularly vulnerable population, who often requires specialized interventions to ensure they have equal opportunities to access services and information. As efforts to address the full range of adolescent health needs move forward, innovative mechanisms to address and track their needs in a sensitive, ethical and robust manner are required.

Table 1: Indicators for the Global Strategy, by target

Target	Included in SDG ("Core")	Additional to SDG ("Complementary")
SURVIVE (END PREVENTABLE MORTALITY)		
Reduce global maternal mortality to less than 70 per 100,000 live births (SDG 3.1)	Maternal mortality ratio (3.1.1)	Proportion of women aged 15-49 who received 4 or more antenatal care visits
	Proportion of births attended by skilled health personnel (3.1.2)	Proportion of women who have postpartum contact with a health provider within 2 days of delivery
Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)	Neonatal mortality rate (3.2.2)	Stillbirth rate
		Proportion of infants who were breastfed within the first hour of birth
		Proportion of newborns who have postnatal contact with a health provider within 2 days of delivery
		Proportion of women in antenatal care (ANC) who were screened for syphilis during pregnancy
Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)	Under-5 mortality rate (3.2.1)	Percentage of children with diarrhoea receiving oral rehydration salts (ORS)
		Proportion of children with suspected pneumonia taken to an appropriate health provider
		Percentage of infants <6 months who are fed exclusively with breast milk
		Percentage of children fully immunized
		Use of insecticide-treated nets (ITNs) in children under 5 (per cent of children)
End epidemics of HIV, tuberculosis, malaria, neglected tropical diseases and other communicable diseases (SDG 3.3)	Number of new HIV infections per 1,000 uninfected population, by age and sex (3.3.1)	Percentage of people living with HIV who are currently receiving antiretroviral therapy (ART), by age and sex
	Malaria incident cases per 1,000 persons per year (3.3.3)	Proportion of households with at least 1 ITN for every 2 people and/or sprayed by indoor residual spray (IRS) within the last 12 months
Reduce by 1/3 premature mortality from non-communicable diseases and promote mental health and well-being (SDG 3.4)	Age-standardized prevalence of current tobacco use among persons 15 years and older by age and sex (3.a.1) [age disaggregated]	Adolescent mortality rate, by sex
	Mortality between ages 30 and 70 years from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases, by sex (3.4.1)	Proportion of women aged 30-49 who report they were screened for cervical cancer
	Suicide mortality rate, by age and sex (3.4.2)	

Target	Included in SDG ("Core")	Additional to SDG ("Complementary")
THRIVE (PROMOTE HEALTH AND WELL-BEING)		
End all forms of malnutrition, and address the nutritional needs of adolescent girls, pregnant and lactating women and children (SDG 2.2)	Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (2.2.1)	Prevalence of insufficient physical activity among adolescents
	Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting and overweight) (2.2.2)	Prevalence of anaemia in women ages 15-49, disaggregated by age and pregnancy status
		Proportion of children 6-23 months of age who receive a minimum acceptable diet
Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)	Percentage of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods (3.7.1)	Proportion of men and women aged 15-24 with basic knowledge about sexual and reproductive health services and rights
	Adolescent birth rate (10-14, 15-19) per 1,000 women in that age group (3.7.2)	
	Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (5.6.1)	
	Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information, and education (5.6.2)	
Ensure that all girls and boys have access to good quality early childhood development (SDG 4.2)	Percentage of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex (4.2.1)	
	Participation rate in organized learning (one year before the official primary entry age), by sex (4.2.2)	
Substantially reduce pollution-related deaths and illnesses (SDG 3.9)	Mortality rate attributed to household and ambient air pollution, by age and sex (3.9.1)	
	Proportion of population with primary reliance on clean fuels and technology (7.1.2)	
Achieve universal health coverage, including financial risk protection, and access to quality essential services, medicines and vaccines (SDG 3.8)	Coverage of essential health services (index based on tracer interventions that include reproductive, maternal, newborn and child health, infectious diseases, non-communicable diseases and service capacity and access) (3.8.1) [including RMNCAH: Family planning; Pregnancy and childbirth care; Breastfeeding; Immunization; Childhood illnesses treatment]	Current country total health expenditure per capita (including on specifically RMNCAH) financed from domestic sources
	Proportion of people with financial protection (3.8.2) – (proposed by WHO and the World Bank)	Out of-pocket health expenses as percentage of total health expenditure

Target	Included in SDG ("Core")	Additional to SDG ("Complementary")
TRANSFORM (EXPAND ENABLING ENVIRONMENTS)		
Eradicate extreme poverty (SDG 1.1)	Proportion of population below the international poverty line, by sex, age, employment status and geographical location (1.1.1)	
Ensure that all girls and boys complete free, equitable and good quality primary and secondary education (SDG 4.1)	Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex (4.1.1)	
Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)	Percentage of women aged 20-24 years who were married or in a union before age 15 and before age 18 (5.3.1)	Proportion of young women and men aged 18-29 years who experienced sexual violence by age 18 (16.2.3)
	Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner in the previous 12 months, by form of violence and by age (5.2.1)*	Proportion of rape survivors who received HIV post-exposure prophylaxis (PEP) within 72 hours of an incident occurring
	Proportion of women and girls aged 15-49 who have undergone female genital mutilation/cutting (FGM/C), by age (5.3.2)	
	Whether or not legal frameworks are in place to promote, enforce, and monitor equality and non-discrimination on the basis of sex (5.1.1)	
Achieve universal and equitable access to safe and affordable drinking water and to adequate sanitation and hygiene (SDG 6.1 and 6.2)	Percentage of population using safely managed drinking water services (6.1.1)	
	Percentage of population using safely managed sanitation services including a hand-washing facility with soap and water (6.2.1)	
Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 8.2)	Research and Development expenditure as a proportion of GDP (9.5.1) [disaggregated by health/RMNCAH]	
Provide legal identity for all, including birth registration (SDG 16.9)	Proportion of children under 5 years of age whose births have been registered with a civil authority, by age (16.9.1)	
	Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration (17.19.2)	
Enhance the global partnership for sustainable development (17.16)	Number of countries reporting progress in multi-stakeholder development effectiveness monitoring frameworks that support the achievement of the SDGs (17.16.1)	Governance Index (voice, accountability, political stability and absence of violence, government effectiveness, regulatory quality, rule of law, control of corruption)
Additional equity, humanitarian, and human rights cross-cutting indicators	Proportion of indicators at the national level with full disaggregation when relevant to the target (17.18.1) [for indicators from the *Global Strategy for Women's, Children's and Adolescents' Health*, this indicator would be relevant at regional, global levels too]	Proportion of countries that have ratified human rights treaties related to women's, children's, and adolescents' health
		Humanitarian Response Index

Legend
Red: Indicators that are adolescent-specific (age-disaggregated)
Blue: Indicators that are for the whole population, but may not be age-segmented for 10-19 year olds

**Indicator for SDG 3.8.2 proposed by the World Health Organizations and the World Bank*

Table 2: *Global Strategy* Indicators (by focal population)

GLOBAL STRATEGY (2016-2030) TARGETS	Women	Children	Adolescents
Reduce global maternal mortality to less than 70 per 100,000 live births (SDG 3.1)			
Maternal mortality ratio (3.1.1)	√		+
Proportion of births attended by skilled health personnel (3.1.2)	√		+
Proportion of women aged 15-49 who received 4 or more antenatal care visits	√		√
Proportion of women who had postpartum contact with a health provider within 2 days	√		+
Maternal cause of death (direct/indirect)	√		+
Proportion of women with obstetric complications due to abortion	√		+
Antenatal, Intrapartum, and Postpartum quality of care, including satisfaction with services received	√		
Reduce newborn mortality to at least as low as 12 per 1000 live births in every country (SDG 3.2)			
Neonatal mortality rate (3.2.2)		√	
Stillbirth rate		√	
Proportion of infants who were breastfed within the first hour of birth		√	
Proportion of newborns who had postnatal contact with a health provider within 2 days		√	
Causes of newborn deaths		√	
Measurement of prevalence of low birth weight and small for gestational age		√	
Postnatal quality of care		√	
Newborn care coverage: treatment of severe neonatal bacterial infection; resuscitation initiated; thermal care; care for small and sick newborns		√	
Reduce under-5 mortality to at least as low as 25 per 1000 live births in every country (SDG 3.2)			
Under-5 mortality rate (3.2.1)		√	
Percentage of infants <6 months who are fed exclusively with breast milk		√	
Full childhood immunization coverage		√	
Percentage of children with diarrhoea receiving oral rehydration salts (ORS)		√	
Proportion of children with suspected pneumonia taken to an appropriate health provider		√	
Use of insecticide-treated nets in children under-5 (per cent of children)		√	
Treatment of sick children: diarrhoea, pneumonia and malaria		√	
Causes of child deaths		√	
End epidemics of HIV, tuberculosis, malaria , neglected tropical diseases and other communicable diseases (SDG 3.3)			
Number of new HIV infections per 1,000 uninfected population, disaggregated by age and sex (3.3.1)	√	√	√
Malaria incident cases per 1,000 persons per year (3.3.3)	0	0	0
Percentage of people living with HIV who are currently receiving antiretroviral therapy (ART), by age and sex and age	√	√	√
Proportion of households with at least 1 ITN for every 2 people and/or sprayed by indoor residual spray (IRS) within the last 12 months	0	0	0
Human papillomavirus (HPV) vaccine coverage among adolescents			√

***GLOBAL STRATEGY* (2016-2030) TARGETS**	**Women**	**Children**	**Adolescents**
Reduce by 1/3 premature mortality from NCDs and promote mental health and well-being (SDG 3.6)			
Age-standardized prevalence of current tobacco use among persons 15 years and older , disaggregated by age (3.a.1)	√		√
Suicide mortality rate, by age and sex (3.4.2)	+	+	+
Adolescent mortality rate, by sex			√
Proportion of women aged 30-49 who report they were screened for cervical cancer	√		
Prevalence of depression, by age and sex	+	+	+
Adolescent cause of death			√
Harmful use of alcohol among adolescents			√
End all forms of malnutrition, and address the nutritional needs of adolescent girls, pregnant and lactating women and children (SDG 2.2)			
Prevalence of stunting (height for age <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age (2.2.1)		√	
Prevalence of malnutrition (weight for height >+2 or <-2 standard deviation from the median of the WHO Child Growth Standards) among children under 5 years of age, by type (wasting, overweight) (2.2.2)		√	
Prevalence of insufficient physical activity among adolescents			√
Prevalence of anaemia in women aged 15-49, disaggregated by age and pregnancy status	√		√
Proportion of children 6-23 months of age who receive a minimum acceptable diet (apart from breastmilk)		√	
Ensure universal access to sexual and reproductive health-care services (including for family planning) and rights (SDG 3.7 and 5.6)			
Percentage of women of reproductive age (15-49) who have their need for family planning satisfied with modern methods (3.7.1)	√		√
Adolescent birth rate (10-14, 15-19) per 1,000 women in that age group (3.7.2)			√
Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (5.6.1)	√		√
Number of countries with laws and regulations that guarantee women aged 15-49 access to sexual and reproductive health care, information, and education (5.6.2)	√		√
Proportion of men and women aged 15-24 with basic knowledge about sexual and reproductive health and rights (SRHR)	√		√
Proportion of secondary schools that provide comprehensive sexuality education			√
Ensure that all girls and boys have access to good quality early childhood development (SDG 4.2)			
Percentage of children under 5 years of age who are developmentally on track in health, learning and psychosocial well-being, by sex (4.2.1)		√	
Participation rate in organized learning (1 year before the official primary entry age), by sex (4.2.2)		√	
Substantially reduce pollution-related deaths and illnesses (SDG 3.9)			
Mortality rate attributed to household and ambient air pollution (3.9.1) [by age and sex]	0	0	0
Proportion of population with primary reliance on clean fuels and technology (7.1.2)	0	0	0
Achieve universal health coverage, including financial risk protection, and access to quality essential services, medicines and vaccines (SDG 3.8)			
Coverage of essential health services (including RMNCAH) (3.8.1)	0	0	0
Proportion of the population with financial protection (3.8.2)	0	0	0
Current country total health expenditure per capita financed from domestic sources (for RMNCAH)	0	0	0
Out-of-pocket expenditure as Percentage of total health expenditure	0	0	0

***GLOBAL STRATEGY* (2016-2030) TARGETS**	**Women**	**Children**	**Adolescents**
Eradicate extreme poverty (SDG 1.1)			
Proportion of population below international poverty line (sex, age, employment) (1.1.1)	0	0	0
Ensure that all girls and boys complete free, equitable and good quality secondary education (SDG 4.1)			
Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex (4.1.1)		√	√
Indicator of youth disenfranchisement			√
Eliminate all harmful practices and all discrimination and violence against women and girls (SDG 5.2 and 5.3)			
Percentage of women aged 20-24 who were married or in a union before age 15 and before age 18 (5.3.1)		√	√
Proportion of ever-partnered women and girls aged 15 years and older subjected to physical, sexual or psychological violence by a current or former intimate partner, in the last 12 months, by form of violence and by age group (5.2.1)	√		√
Proportion of women and girls aged 15-49 who have undergone female genital mutiliation/cutting (FGM/C), by age (5.3.2)	√		√
Whether or not legal frameworks are in place to promote, enforce, and monitor equality and non-discrimination on the basis of sex (5.1.1)	√	√	√
Proportion of young women and men aged 18-29 who experienced sexual violence by age 18 (16.2.3)		√	√
Proportion of rape survivors who received HIV post-exposure prophylaxis (PEP) with 72 hours of an incident occurring	0	0	0
Health sector specific indicator on discrimination	0	0	0
Percentage of the population reporting having personally felt discriminated against or harassed within the last 12 months on the basis of a ground of discrimination prohibited under international human rights law, disaggregated by age and sex (10.3.1)	+		+
Achieve universal and equitable access to safe and affordable drinking water and to adequate sanitation and hygiene (SDG 6.1 and 6.2)			
Percentage of population using safely managed sanitation services including a hand washing facility with soap and water (6.2.1)	0	0	0
Percentage of population using safely managed drinking water services (6.2.2)	0	0	0
Enhance scientific research, upgrade technological capabilities and encourage innovation (SDG 8.2)			
Research & Development expenditure as a proportion of GDP (disaggregated by health/RMNCAH) (9.5.1)	0	0	0
Proportion of countries that have systematic innovation registration mechanisms in place for women's, children's, and adolescents' health (WCAH) and are reporting top 3 domestic innovations on an annual basis	0	0	0
Proportion of countries that have mechanisms to review innovations using effective Health Technology Assessment Approaches	0	0	0
Provide legal identity for all, including birth registration (SDG 16.9)			
Percentage of under-five births that have been registered with the civil authority, Disaggregated by age (16.9.1)		√	
Proportion of countries that (a) have conducted at least one population and housing census in the last 10 years; and (b) have achieved 100% birth registration and 80% death registration (17.19.2)	0	0	0

***GLOBAL STRATEGY* (2016-2030) TARGETS**	**Women**	**Children**	**Adolescents**
Enhance the global partnership for sustainable development (17.16)			
Number of countries reporting progress in multi-stakeholder development effectiveness monitoring frameworks that support the achievement of the SDGs (17.16.1)	0	0	0
Governance Index (voice, accountability, political stability and absence of violence, government effectiveness, regulatory quality, rule of law, control of corruption)	0	0	0
Does the national RMNCAH strategy/plan of action specify that there should be community participation in decision-making, delivery of health services and monitoring and evaluation?	0	0	0
Proportion of countries that address young people's multisectoral needs within their national development plans and poverty reduction strategies (16.7.2)	0	0	0
Participation measures – women's groups, youth, civil society etc.	0	0	0
Implementation rate of commitments to the *Global Strategy*	0	0	0
Equity, humanitarian, and human rights as cross-cutting considerations			
Proportion of indicators at the national (regional, global) level with full disaggregation when relevant (for GS indicators) (17.18.1)	0	0	0
Ratification of human rights treaties related to women's, children's, and adolescents' health	0	0	0
Humanitarian Response Index	0	0	0
Health-sector specific indicators on anti-corruption and transparency	0	0	0
Percent of programmes in humanitarian settings based on health needs assessments of women, children and adolescents	0	0	0
Funding gap in the transition from humanitarian aid to sustainable development	0	0	0

Legend:

√ *Covers that population, including specified age ranges*

\+ *Covers that population if age disaggregated (no specified age range)*

0 *Applicable to all*

Core indicator (Additional to SDG); *Core indicator (Additional to SDG);* Indicator for development

Part 5: Annexes

Annex A: Sources of Data

Gathering adequate information to plan and develop effective strategies to improve adolescent health can be a challenge as there are significant gaps in data coverage. Household surveys commonly used to gather demographic and health information (e.g. Demographic and Household Surveys and Multiple Indicator Cluster Surveys) mostly focus on samples of men and women aged over 15 years of age, which means many key indicators cannot be calculated for the 10-14 adolescent age group. Most studies aimed to collect data specifically on adolescents only sample those attending school, which means those not in education are omitted. This excluded group may have very different needs and experiences, and it means the sample is concentrated among early adolescents. There is very little data available about some aspects of adolescent health and well-being such as mental health, disability and chronic diseases. While data from some of the surveys can be disaggregated to show socio-economic, geographic and ethnic inequities it is not possible to use them to identify or understand the needs of some particularly vulnerable or marginalised groups (e.g. migrants, commercial sex workers, domestic servants, lesbian, gay, bisexual and transsexual youth, adolescents orphaned or separated from their families) and this often requires specific, targeted research.

In addition, the quality of available data from surveys may not always be optimal. Adolescents may be reluctant to report behaviours or experiences that are socially proscribed, stigmatizing or illegal, resulting in underestimation of particular issues or concerns.

Cross-National Surveys

A number of cross national surveys are available which provide the majority of information on indicators for adolescents in low and middle-income countries. In some cases these datasets can be accessed directly to enable primary analysis of particular issues, or disaggregation by sub-groups. Alternatively some produce reports (either country-specific or thematic) which present data on key indicators.

- **Demographic and Household Surveys (DHS)**. The DHS has over 300 large-scale, nationally-representative surveys in 90 low and middle-income countries. It provides data on a number of health and demographic indicators comparable across time and place. Areas covered include: age at first birth, first sex and first marriage/union, mortality data, sexual knowledge, attitudes and behaviours (15 year only), contraceptive use and unmet need for contraception (>15 years only), reproductive health care utilisation, HIV prevalence (>15 years only), anaemia prevalence, anthropometric measures and other biomarkers, tobacco and alcohol use (>15 years only), gender and domestic violence (>15 years only), women's empowerment (>15 years only), education and employment, access to mass media (>15 years only), and household characteristics.

  Some countries have AIDS surveys which provide comprehensive data on sexual behaviours for women and men >15 years.

  The most comprehensive survey module samples women ages 15-45 (or 49) years. Some surveys only sample married women. The men's survey (again using a sample of men over the age of 15) usually has a smaller sample and covers less topics. There is limited data on adolescents <15 years. Data can be disaggregated by socio-economic, ethnic and geographic characteristics.

  Individual country reports as well as the full datasets can be found at http://www.dhsprogram.com/. Alternatively, many indicators can be obtained through http://www.statcompiler.com/.

- **Multiple Indicator Cluster Surveys (MICS).** These are around 280 large-scale surveys implemented in more than 100 low- and middle-income countries providing data on a range of health and demographic indicators, and many are representative at the national or sub-national level. Areas covered include age at first birth, first sex and first marriage / union, sexual knowledge, attitudes and behaviours (>15 years only), contraceptive use and unmet need for contraception (>15 years only), reproductive health care utilisation, tobacco and alcohol use (>15 years only for tobacco use), gender and domestic violence (>15 years only), women's empowerment (>15 years only), access to mass media (including internet: >15 years only), education, employment and child labour, child discipline, household characteristics, orphanhood and subjective well-being. Sample characteristics are similar to the DHS.

  Surveys and country reports can be found at http://mics.unicef.org/surveys, and many indicators can be displayed using the MICS compiler tool http://www.micscompiler.org/.

- **Global School-Based Student Health Survey (GSHS).** GSHS are self-administered questionnaires carried out in over 100 low and middle-income countries to assess the behavioural risk factors and protective factors among young people in school aged 13 to 17 years. Areas covered include alcohol, tobacco and drug use, dietary behaviours, hygiene, mental health, physical activity, sexual behaviour, protective factors and violence and unintentional injury. They only sample adolescents in school. Further information and country fact sheets can be found at: http://www.who.int/chp/gshs/methodology/en/

- **The World Mental Health Survey Initiative.** These surveys, which are supported by WHO, provide data (at either regional or national level) on a range of mental and behavioural disorders for 27 countries (mostly middle and high income). While many of the surveys only sample those over the age of 18, it provides information on age of onset for some disorders which can be used to provide information on adolescent mental health. http://www.hcp.med.harvard.edu/wmh/index.ph

- **Global Youth Tobacco Survey (GYTS).** The GYTS school-based survey has been carried out in 140 countries since 1998 and is designed to enhance the capacity of countries to monitor tobacco use among youth and to guide the implementation and evaluation of tobacco prevention and control programmes. Data is collected from adolescents aged 13-15 years, and country fact sheets can be found at: https://www.cdc.gov/tobacco/global/gtss/gtssdata/

Other Resources for Accessing Country-Specific Data

There are a number of other data portals, websites and projects that provide data on development indicators (including adolescent health indicators) for low and middle income countries in an easily-accessible format. In some cases the data provided is largely based on findings from the surveys in the previous section.

- **The Population Division of the United Nations Department of Economic and Social Affairs.** The Population Division provides estimates and projections for all countries for a range of indicators, including population and mortality estimates in five-year age groupings for both sexes, and adolescent fertility estimates 15-19 years. http://esa.un.org/unpd/wpp/Download/Standard/Population/

- **UNFPA** has developed an animated and interactive Adolescent and Youth Data Dashboard that provides a range of disaggregated indicators for low and middle income countries which can be used to identify the most vulnerable adolescents. Domains of interest include adolescent population size and distribution, adolescent sexual and reproductive health (e.g., sexual activity, contraceptive prevalence rate, unmet need, demand for family planning satisfied, comprehensive HIV knowledge), harmful practices (e.g., child marriage and female genital mutilation/cutting), and women's empowerment. Indicators can be disaggregated by sex, age subgroups, school attendance, marital status, residence, living arrangement, rural-urban distribution, etc. http://dashboard.unfpaopendata.org/ay/index.php

- **The World Bank** is a vital source of financial and technical assistance to developing countries around the world and provides free and open access to data about development in countries around the globe. There are some indicators for youth (ages 15-24) data.worldbank.org/

- **The Institute for Health Metrics and Evaluation – Data on Burden of Disease**: The Global Burden of Diseases, Injuries, and Risk Factors Study (GBD) is the largest and most comprehensive effort to date to measure epidemiological levels and trends worldwide, and provides estimates for some causes of death by five-year and age group (including 10-14 and 15-19 years) by country using a visualization tool: http://vizhub.healthdata.org/cod/.

- **The Lancet** provides occasional detailed reviews of disease-specific or regional health information. Most global health content is free to all users. www.thelancet.com/global-health/. In 2012 it published a series of four papers on adolescent health which analyses the role of adolescence as a foundation for future health, the social determinants of adolescent health, the potential of the worldwide application of prevention science, and the current availability of data on 25 suggested core indicators in all countries. http://www.thelancet.com/series/adolescent-health-2012

  The Lancet Commission on Adolescent Health and Well-Being report, which launched in May 2016, provides a narrative and integrated work plan for responding to the shifting determinants of health and health needs of the world's adolescents and young adults. http://thelancetyouth.com/

Annex B: Resources, Promising Approaches, and Tools

A strong evidence base should be applied when selecting any intervention. This is true for any of the three intervention areas included in the *Global Strategy*: survive, thrive and transform. Although the evidence base of adolescent health is still being built, a list of resources, promising approaches and tools are listed below to promote the use of good practices informed by the evidence.

- The World Health Organization provides up-to-date, evidence-based recommendations on effective health interventions. A summary of all the current recommendations that relate to adolescent health is given in the 2014 WHO online report "Health for the World's Adolescents: A second chance in the second decade." The report also provides global and regional estimates of the burden of disease among adolescents by five-year age groups and by sex).

- WHO (2015) *Global Standards for Quality Health Care Services for Adolescents* aims to assist policy-makers and health service planners 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.

- WHO (2015) *Core Competencies in Adolescent Health and Development for Primary Care Providers* aims to help countries develop competency-based educational programmes in adolescent health and development in both pre-service and in-service education. In addition, it provides guidance on how to assess and improve the structure, content and quality of the adolescent health component of pre-service curricula.

- WHO (2012) *Making Health Services Adolescent Friendly: Developing national quality standards for adolescent friendly health services* set out the public health rationale for making it easier for adolescents to obtain the health services that they need to protect and improve their health and well-being, including sexual and reproductive health services. It defines 'adolescent-friendly health services' from the perspective of quality and provides step-by-step guidance on developing quality standards for health service provision to adolescents.

- WHO (2009) *Quality Assessment Guidebook: A guide to assessing health services for adolescent clients* is part of a set of tools to strengthen programmatic action on adolescent health in countries. It is intended to enable programme managers to assess the quality of health service provision to adolescents, and to take appropriate action where the quality is found wanting. The guide includes data collection instruments that can be adopted per context.[9]

- WHO (2011) *Preventing Early Pregnancy and Poor Reproductive Outcomes among Adolescents in Developing Countries* provides a call to action and directions for future research on issues addressing: child, early and forced marriage; contraceptive use; coerced sex; unsafe abortions; and skilled antenatal, childbirth and postnatal care. It is intended for policy makers, planners and programme managers from governments, NGOs, and development agencies.

- UNFPA supports countries to identify and implement policies and programmes to secure the health, development and human rights of adolescents and youth, focusing on five key areas: (1) evidence-based advocacy; (2) comprehensive sexuality education; (3) adolescent-responsive sexual and reproductive health information and services; (4) bold initiatives to reach marginalized adolescent girls; and (5) youth leadership and participation. The UNFPA flagship publication, State of World Population, has covered adolescents extensively:

  - *10: How Our Future Depends on a Girl at this Decisive Age (2016)*
  - *The Power of 1.8 Billion: Adolescents, Youth and the Transformation of the Future (2014)*
  - *Motherhood in Childhood: Facing the Challenge of Adolescent Pregnancy (2013)*

9 This WHO resource builds on the ExpandNet Strategic Assessment methodology found at www.expandnet.net

- UNFPA (2015) *Girlhood, not Motherhood: Preventing Adolescent Pregnancy* presents strategic thinking and reviews the best available evidence on effective strategies and interventions to empower girls and reduce their vulnerability to adolescent pregnancy. Drawing from evaluated evidence, it provides guidance on how to implement effective programmes that operate at multiple levels and with various stakeholders, including and most importantly, with the adolescent girl.

- UNFPA (2015) *Evaluation of Comprehensive Sexuality Education Programmes: a Focus on the Gender and Empowerment Outcomes* offers a review and analysis of evaluation studies on different comprehensive sexuality education programmes at various stages of development. It discusses new methodologies, available questionnaires, and instruments that can be applied in assessments and evaluations to measure gender and empowerment outcomes.

- UNFPA and Center for Reproductive Rights (2013) *Reproductive Rights: a Tool for Monitoring State Obligations* provides a means for human rights experts to monitor the implementation of specific state obligations on a range of reproductive rights issues. It includes key questions that human rights experts and monitoring bodies can use to assess state compliance, including in relation to laws and regulations affecting adolescents and youth, who are identified to require special consideration.

- *The UN International Technical Guidance on Sexuality Education* (2009), commissioned by UNESCO, in partnership with UNAIDS, UNFPA, UNICEF and WHO, seeks to assist education, health and other relevant authorities to develop and implement school-based sexuality education materials and programmes. An update of the guidance is expected in 2017.

- *UNAIDS Guidance Note on HIV Prevention, Treatment, Care and Support for Adolescents and Youth* (2014) provides an overview of effective HIV responses designed for adolescents and youth for the purposes of strengthening national responses. It is part of a resource kit for high-impact programming to provide practical guidance on key areas of the AIDS response.

Other Resources and Tools

- ExpandNet is a global network that seeks to advance the science and practice of scaling up. ExpandNet has produced a number of resources and tools including guidance documents, worksheets, and checklists to plan ahead for eventual scale up from the earliest stages of designing programmes. The methodologies have also been applied to conduct rapid programme reviews on adolescent health as part of a systematic process for scaling up interventions.

- The Population Council conducts research to understand girls' circumstances and what works best to improve their lives. The Council has a number of tools and resources on girl-centered programming, including how to identify which girls are most vulnerable and where they are geographically located, as well as strategies for reducing their risks and increasing their opportunities by building their protective assets. The Council has also conducted extensive research on very young adolescents (10-14 year olds), including a review on the evidence on programme interventions and areas for future research.

- OneHealth Tool provides planners with a single framework for scenario analysis, costing, health impact analysis, budgeting and financing of strategies for all major diseases and health system components.

- *The Assessment of Adolescent Health Interventions in GAVI HPV Vaccine Demonstration Programmes* is a toolkit that consists of an overview of the adolescent health intervention assessment (the context, objectives, timelines, and budget. The appendix has the tool and templates to guide activities such as data collection, prioritization of health interventions, and report writing.

- *How to Conduct a Coverage Exercise: a Rapid Assessment Tool for Programs and Services* is a simple, rapid assessment tool by the Population Council that can be used to profile who is reached by a given service or group of service providers, or organizations with a common clientele (e.g., adolescents and youth). It can be used for a range of services in facilities and those conducted on an outreach basis.

- *Thinking Outside the Box: A Decision-Making Tool for Designing Youth-Friendly Services* seeks to advance services tailored to young people's needs by helping programme designers select and adapt appropriate youth-friendly service delivery models, considering: the country context, the target population, the desired behavioural and health outcomes, the services offered, and the needs and objectives for scalability and sustainability.

- *Youth Participation Guide: Assessment, Planning and Implementation* seeks to increase the level of meaningful youth participation in reproductive health and HIV and AIDS programming at an institutional and programmatic level.

- Restless Development is a youth-led development agency that aims to place young people at the forefront of change and development. They are a pioneer in youth leadership and have developed resources and toolkits on youth-led advocacy, community assessments, and grassroots mobilization.

- U-report is a free, SMS-based system that allows young people to speak out on what is happening in communities across their country, and work together with other community leaders and policy makers for positive change.

- Knowledge for Health (K4Health) shares accurate, up-to-date knowledge and tools to strengthen family planning and other public health efforts worldwide.

- PubMed is a service of the United States National Library of Medicine that provides free access to its database of indexed citations and abstracts to medical, nursing, dental, health care and preclinical sciences journal articles.

- World Bank Gender provides a gateway to a gender data portal, gender-related impact evaluations and links to the World Development Report.

Annex C: Developing a Country Investment Case for the Global Financing Facility in support of *Every Womand Every Child*

The Global Financing Facility in support of *Every Woman Every Child* (GFF) is a new financing model that provides a platform that brings together resources from countries, international donors, and the private sector to accelerate advancements in the health of women, children, and adolescents.

The "Investment Case" is at the core of GFF country financing. The objective is to have a nationwide, evidence-based, prioritized plan with a clear focus on results that both guides and attracts additional financing from the entire set of GFF partners (including national governments) over a three to five-year period. A country-specific approach is essential given the large differences between countries in the existence and quality of evidence and current plans. Although it covers three to five years, the Investment Case is developed with a long term perspective that emphasizes the priority obstacles that must be overcome for a country to start the trajectory needed to attain the Sustainable Development Goal targets by 2030.

Developing an Investment Case involves several steps which build on existing national planning processes. In line with the principle of country ownership, the GFF approach is flexible and does not insist on rigid application of these steps. Instead, the GFF focus is on the objective – a rigorous analysis of data that enables an inclusive set of stakeholders to identify, prioritize, and cost the interventions that set a country on a course to achieving 2030 targets.

The ***first step*** is a country consultative process that is informed by core analytics. Stakeholders discuss the RMNCAH results to be achieved by 2030 at the level of impact indicators (e.g., maternal mortality ratio, neonatal mortality rate, adolescent birth rate). Stakeholders also discuss the major opportunities for improvement in a country's health systems at sub-national as well as national level that would facilitate reaching these results.

Key multisectoral issues impacting RMNCAH outcomes are also reviewed. The purpose of this exercise is to identify the focus areas that stakeholders, based on their assessment of the data, consider the most important. There is a particular emphasis in this process on areas that have historically been under-funded (e.g., family planning, nutrition) and on specific target populations that have historically been neglected (e.g., adolescents).

Civil registration and vital statistics (CRVS) is a key area in this regard and is fully integrated in the Investment Case. Both the effectiveness and efficiency of service delivery mechanisms (in both public and private sectors) are also key elements to be addressed in this stage.

The second step in the process is to conduct a detailed analysis of each of the areas identified in the first step. This examines four main dimensions of each obstacle: supply factors, demand factors, the enabling environment, and factors outside the health sector that are nonetheless important to understanding the obstacle, including the social determinants of health (e.g., gender norms, weak sanitation systems undermining the effectiveness of disease control measures, insufficient data for decision-making due to poor CRVS systems). Additionally, a robust resource mapping that covers both domestic and international resources is a critical input, since it determines the parameters for what is feasible.

Stakeholders then determine and agree on the results to be achieved in each area. These results are at a lower level than in step 1, and so are typically at the outcome and output levels rather than impact level. In keeping with the GFF's equity focus, equity analyses are essential at this stage to ensure that disadvantaged and vulnerable populations are identified and prioritized. Attention to gender and rights (including reproductive rights) is also critical. It is expected that issues (e.g., family planning, nutrition) and populations (e.g., adolescents) that have historically been underinvested are adequately included in the GFF Investment Cases.

Having clarity on the desired results enables the formulation of a package of interventions required both in the long and short terms. These solutions should build on what has been demonstrated to work in a given country as well as on the transformative initiatives that can accelerate progress. The balance between RMNCAH service delivery, health systems strengthening, and multi-sectoral responses is dependent on the country context and the outcome of the core analytics. In addition to comparing interventions, the

prioritization process also addresses the shifts needed in service delivery to overcome obstacles. This encompasses both the mode of delivery (e.g., public, private, or non-profit) and the location of delivery (e.g., facility, community, or household). Complementary elements such as community engagement and advocacy are also included.

The Investment Case should contain a clear theory of change that demonstrates how all of the parts contribute to achieving the long term vision. This also enables the development of a clear results framework that includes indicators, targets, and data sources. This facilitates regular assessments of the progress in following through on an Investment Case, which promotes mutual accountability for results and so is a core element of all Investment Cases.

A common set of indicators will be included in all Investment Case results frameworks.

These will be drawn primarily from international agreements (e.g., the Sustainable Development Goals) but will also include indicators below the impact level so that changes in outcomes (e.g., related to coverage of high-impact interventions) can be tracked across countries.

The final step of the process is costing, which provides critical information that is factored into the decision-making around which solutions feature in the Investment Case.

The costing should include all elements necessary to deliver upon the Investment Case (including commodities and human resources) and should be done based on accepted costing methodologies (e.g., The OneHealth Tool, the Marginal Budgeting for Bottlenecks tool).

Technical assistance is important throughout the process of preparing an Investment Case to bring in evidence and good practices from other settings, provide technical guidance based on international standards, share lessons learned, and contribute to the core analytics. As a general principle, the GFF approach prioritizes the delivery of technical assistance in ways that build sustainable capacity and transfer skills, such as through training new staff and building the capacity of existing staff, supporting the strengthening of institutions, and building an environment conducive to capacity development. In doing so, the GFF builds on existing structures and processes for technical assistance, including in-country processes organized by the H6 organizations, South-South cooperation, and regional support mechanisms (including for CRVS).

Annex D: Adolescent and Youth Issues in the Sustainable Development Goals

Goals 1 and 2 (Poverty and Hunger): Adolescents and youth are disproportionately represented among people living in poverty and are denied access to economic resources. Investments in adolescents are crucial for countries to grow their economies and reap the demographic dividend. Children and adolescents are also among the most vulnerable to climate-related extreme events and other disasters, and should be a focus of programmes on resilience.

- Targets 1.1 and 1.2 call for the eradication of extreme poverty for all people everywhere, as well as reducing by half the proportion of children of all ages living in poverty in all its definitions.
- Target 2.2 specifically commits to addressing adolescent girls' nutritional needs by 2025.

Goal 3 (Health and Well-Being): A focus on adolescents is crucial for achieving the health goal. Not only do adolescents have the least access to health information and services, particularly on sexual and reproductive health, but the primary risk factors for non-communicable diseases (NCDs) – tobacco use, alcohol abuse, unhealthy diet, and insufficient exercise — are behaviours that begin in early adolescence.[10] Adolescent girls are at higher risk of maternal mortality and morbidity, and while AIDS-related deaths have fallen for every other age group, they have risen dramatically for adolescents.

- Target 3.1 commits to reducing the global maternal mortality ratio to less than 70 per 100,000 live births by 2030.
- Target 3.3 commits to end the epidemic of AIDS and other diseases.
- Target 3.7 calls for universal access to sexual and reproductive health care services.
- Target 3.8 commits to ensuring universal health coverage, including financial risk protection, access to quality essential health-care services, and access to safe, effective, quality and affordable essential medicines and vaccines to all.

Goal 4 (Education): In order to build on the gains made in primary education and ensure a successful transition to secondary education for all, the focus is on the age group of early adolescence (10-14 years), where most drop-outs occur, particularly for girls. There are 63 million adolescents of lower-secondary school age (12-15 years) who are out of school – 5 million more than children of primary school age, even though there are twice as many primary school-age children worldwide.[11] Education on health, sexuality, gender and human rights is especially important for adolescents considering the rapid physical, emotional and social development they undergo.

- Target 4.1 commits to ensuring that all girls and boys complete free, equitable and quality primary and secondary education by 2030.
- Target 4.5 calls for the elimination of gender disparities in education and ensuring equal access to all levels of education and vocational training for the vulnerable.
- Target 4.6 commits to ensuring that all youth achieve literacy and numeracy by 2030.
- Target 4a calls for the need to build and upgrade education facilities that are gender sensitive and provide safe, non-violent, inclusive and learning environments for all.

Goal 5 (Gender Equality): A focus on adolescent girls is key to achieving the goals on gender equality. Adolescent girls are doubly discriminated due to age and gender, and are among the least empowered to be able to negotiate safe sex and among the most likely to be subjected to harmful practices, such as child, early and forced marriage and female genital mutilation. Almost half of all sexual assaults take place against girls below the age of 16. They are almost entirely absent from decision-making in the political, economic and public life of their communities.

10 Population Reference Bureau http://www.prb.org/Publications/Datasheets/2015/ncd-risk-youth-africa.aspx

11 UNESCO "Fixing the Broken Promise of Education for All" (2015) http://www.uis.unesco.org/Education/Documents/oosci-global-report-en.pdf

- Targets 5.1 and 5.2 commits to ending all forms of discrimination against girls, and to eliminating all forms of violence against girls in the public and private spheres respectively.

- Target 5.3 commits to eliminating all harmful practices, such as child, early and forced marriage and female genital mutilation.

- Target 5.6 commits to ensuring universal access to sexual and reproductive health and reproductive rights according to the Programme of Action for the International Conference on Population and Development, and the Beijing Platform for Action.

- Target 5c commits to adopting and strengthening policies and legislation for the empowerment of girls.

Goal 6 (Water and Sanitation): Clean water, sanitation and good hygiene practices are essential and basic human needs for survival. The lack of clean water and sanitation increases the risk of water-borne diseases and opportunistic infections. Women and girls are also disproportionately affected by lack of access. They often bear the burden of fetching and transporting water, among many other household responsibilities, and consequently miss out on many opportunities for education, productive activities, or rest. When latrines are not easily available in households, women and girls will often wait until dark to seek privacy and relieve themselves, increasing their risk of sexual harassment and assault. Moreover, the lack of sanitation and washing facilities at schools might be a factor among many that discourage girls from attending school when menstruating.

- Target 6.2 seeks commits to achieving access to adequate and equitable sanitation and hygiene for all, paying special attention to the needs of girls.

Goal 8 (Economic Growth, Employment and Decent Work): While adolescents should ideally remain in school through secondary level, the reality is that many are taking up economic activities early in life, often unsafe and at low wages. Early labor force participation is associated with early school leaving and low levels of educational attainment. It is also estimated that the majority of young workers in the age group 15-17 are engaged in some form of hazardous work, which can translate into work-related illness and injury,[12] as well as wide forms of abuse. In general, youth in developing countries are often trapped in working poverty due to the irregularity of work and lack of formal employment and social protection. On the other hand, young people's access to productive, formal employment opportunities that provide a decent wage, relative security and good working conditions are critical components for countries to reap the demographic dividend.

- Target 8.5 commits to achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value by 2030.

- Target 8.6 commits to substantially reduce the proportion of youth not in employment, education or training by 2020.

Goal 10 (Inequalities): Adolescents face multiple discriminations due to their age as it intersects with sex, disability, race, ethnicity, or other status. For many adolescents, sexual and reproductive health services are inaccessible due to legal and policy barriers, in addition to a lack of knowledge and the attitudes of service providers. Young people are also overrepresented among the world's migrants and are often vulnerable to exploitation and abuse in countries of origin, transit and destination.

- Target 10.2 commits to empowering and promoting the social, economic and political inclusion of all, irrespective of age by 2030.

- Target 10.7 commits to facilitating orderly, safe, regular and responsible migration and mobility of people, including through planned and well-managed migration policies.

Goal 11 (Urbanization): 60 per cent of the urban population in developing countries is projected to be less than 18 years of age by 2030. The majority of them will be living in slums and informal settlements. These residents often lack access to services, secure tenure, formal employment opportunities, and legal recognition. Evidence also points toward a heightened risk for poor sexual and reproductive health outcomes among adolescents and youth living in urban poor settlements compared with their wealthier urban counterparts or those in rural settings. While not explicitly mentioned in the targets, the needs of adolescents require special attention.

- Target 11.1 commits to ensuring access for all to adequate, safe and affordable housing and basic services and upgrade slums by 2030

12 ILO (2015). Global Employment Trends for Youth: Scaling up investments in decent jobs for youth

- Target 11.2 commits to providing access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons, by 2030.

Goal 13 (Climate Change): Adolescents and youth today are the generation that has mobilized in unprecedented ways to push for political action on climate change. At the same time, they will need the education, tools, and support to drive change in their organizations, communities and countries. Ultimately, they will be the generation that has to live with its consequences.

- Target 13 commits to promoting mechanisms for raising capacity for effective climate change-related planning and management in Least Developed Countries and Small Island States with a focus on youth.

Goal 16 (Peaceful and Inclusive Societies): Young people in conflict settings commonly are perceived as either perpetrators or victims, often depending on their age, gender or other identity. Yet the lived realities of young people suggest that most young people resist violence, and in many cases, are leading efforts to build peace. Even though children, adolescents and youth, especially young men, have been the foundations on which countries and armed groups have built their armies, they are excluded from decision-making processes despite their large numbers. Further, interpersonal violence is among the leading cause of death of adolescents.[13] With the adoption of the UN Security Council Resolution 2250, there is now greater global awareness of the importance of engaging young people as peacebuilders.

- Target 16.1 commits to reducing all forms of violence and related deaths.

- Target 16.6 commits to developing effective, accountable and transparent institutions.

- Target 16.7 commits to ensuring responsive, inclusive, participatory and representative decision-making at all levels.

Goal 17 (Partnerships): The large numbers of adolescents and youth, and particularly the networks, organizations, and movements led by young people have demonstrated their ability to bring about political and social change. Young people today can be the "Sustainable Development Generation" that is the driving force for implementing this ambitious global agenda. As the generation that has the biggest stake in the future, they will also be at the forefront of holding governments accountable for implementing this agenda.

- Target 17.17 encourages and promotes effective public, public-private and civil society partnerships.

13 World Health Organization, "Health for the Worlds' Adolescents" (2014)

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