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Global Accelerated Action for the Health of Adolescents (AA-HA!)

Guidance to Support Country Implementation – Summary

The Partnership for Maternal, Newborn & Child Health

WE SUPPORT EVERY WOMAN EVERY CHILD

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Foreword

Adolescents are not simply old children or young adults. This deceptively simple observation lies at the heart of Global Accelerated Action for the Health of Adolescents (AA-HA!): Guidance to Support Country Implementation – which reflects the coming of age of adolescent health within global public health.

For years, the unique health issues associated with adolescence have been little understood or, in some cases, ignored. But that has now changed. Adolescent health and development was made an integral part of the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) (the Global Strategy) because, in the words of the United Nations Secretary-General, "[adolescents are] central to everything we want to achieve, and to the overall success of the 2030 Agenda".

Why "central"? Because investments in adolescent health bring a triple dividend of benefits for adolescents now, for their future adult lives, and for the next generation. Their health and well-being are engines of change in the drive to create healthier, more sustainable societies.

In 2014, the WHO report Health for the World's Adolescents showed that considerable gains from investments in maternal and child health programmes are at risk of being lost without corresponding investments in adolescent health. The latest data show that more than 3000 adolescents die every day from largely preventable causes, and that many key risk factors for future adult disease start or are consolidated in adolescence. Adolescent mental health and well-being are often overlooked.

This guidance is a milestone for translating the Global Strategy into action. It provides a wealth of information to policy-makers, practitioners, researchers, educators, donors and civil society organizations – including the most up-to-date data on the major disease and injury burdens that affect adolescents. It supports the implementation of the Global Strategy by providing the comprehensive information that countries need to decide what to do for adolescent health, and how to do it. It builds on ongoing efforts to ensure that adolescents can Survive and Thrive, and are in a position to Transform the societies in which they live.

But the guidance provides much more than facts and figures. It brings a paradigm shift in how we think about and plan for adolescent health.

First, the guidance not only views adolescence through the conventional public health lenses of risk and protective factors, but also considers adolescents to be powerful societal assets whose contributions can be nurtured and augmented through meaningful engagement and participation. The level and quality of inputs to this document from adolescents and young people, including vulnerable groups, lend considerable weight to its recommendations.

Second, the guidance takes a radically different approach to traditional adolescent health programming. In the past, adolescent health advocates have had to look for entry points – such as HIV, or sexual and reproductive health – to access funding to address broader adolescent health issues. We argue that the triple dividend from investing in adolescent health is enough rationale for directing attention and resources to this area in its own right, while making the case for an Adolescent Health in All Policies (AHiAP) approach. In that respect, they recommend key actions that are needed in sectors as diverse as education, social protection, urban planning and the criminal justice system, in order to respect, protect and fulfil adolescents' rights to health.

Third, there is a growing realization that adolescents often face disproportionate risks in humanitarian and fragile settings – including poor physical and mental health, harassment, assault and rape. Adolescent-specific considerations for programming in humanitarian and fragile settings have therefore been explicitly included.

Finally, this guidance not only provides information on what needs to be done – it demonstrates what is already being done. More than 70 case studies from across the globe provide concrete examples of how countries have done what is being promoted.

The partnership that was created while developing this interagency guidance sets the stage for a new era in global adolescent health. Coordinated by WHO, the guidance was developed with the active participation of United Nations agencies; civil society organizations; academics; governments; and, most importantly, young people themselves. This model of engagement puts young people in the driver's seat, consistent with the powerful motto "nothing about us, without us".

At WHO, we believe that this is just the beginning. We look forward to this partnership developing and expanding to support the implementation of the AA-HA! guidance in countries, to ensure that adolescent health and development remain at the centre of national, regional and global health agendas.

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AA-HA!'s overarching messages

Approach

The AA-HA! guidance provides a systematic approach for understanding adolescent health needs, prioritizing these in the country context and planning, monitoring and evaluating adolescent health programmes.

Prevention

More than 3000 adolescents die every day from largely preventable causes such as unintentional injuries; violence; sexual and reproductive health problems, including HIV; communicable diseases such as acute respiratory infections and diarrhoea; noncommunicable diseases, poor nutrition and lack of physical activity; and mental health, substance use and suicide. Even more suffer from ill health due to these causes. Although much research is still needed, effective interventions are available for countries to ACT NOW.

Priority setting

The nature, scale and impact of adolescent health needs vary between countries, between age groups and between the two sexes. Funds are limited, and governments should prioritize their actions according to the disease and injury risk factor profiles of their adolescent population, as well as the cost-effectiveness of the interventions. Adolescent health needs intensify in humanitarian and fragile settings.

AA-

HA!

Leadership

Strong leadership at the highest level of government should foster implementation of adolescent-responsive policies and programmes. To accelerate progress for adolescent health, countries should consider institutionalizing national adolescent health programmes. Through the Sustainable Development Goals and the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030), globally agreed targets related to adolescent health exist, along with indicators to monitor progress towards these. Age and sex disaggregation of data will be essential.

Yields from investing in adolescent health span across generations

There is a pressing need for increased investment in adolescent health programmes, to improve adolescent health and survival in the short term, for their future health as adults, and for the next generation. This is a matter of urgency if we want to curb the epidemic of noncommunicable diseases, to sustain and reap the health and social benefits from the recent impressive gains in child health, and ultimately to have THRIVING and peaceful societies.

Together

WITH adolescents, FOR adolescents. Adolescents have particular health needs related to their rapid physical, sexual, social and emotional development and to the specific roles that they play in societies. Treating them as old children or young adults does not work. National development policies, programmes and plans should be informed by adolescents' particular health-related needs, and the best way to achieve this is to develop and implement these programmes with adolescents.

Whole-of-government. To achieve the Sustainable Development Goal targets, the health and other sectors need to normalize attention to adolescents' needs in all aspects of their work. An Adolescent Health in All Policies (AHiAP) approach should be practised in policy formulation, implementation, monitoring and evaluation.

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1. A call for accelerated action for the health of adolescents

Today there is an unprecedented opportunity to improve adolescent health and to respond more effectively to adolescents' needs. The Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) identifies adolescents as being central to achieving the Sustainable Development Goals (SDGs) (1).

Building on the momentum created by the SDGs and the Global Strategy, the AA-HA! guidance provides technical guidance to policy-makers and programme managers as they respond to the health needs of adolescents in their countries.

Led by WHO, this guidance document was developed in consultation with adolescents and young people, Member States, United Nations agencies and civil society organizations and other partners, and is endorsed by the Every Woman Every Child (EWEC) initiative, the Partnership for Maternal, Newborn & Child Health (PMNCH), UNAIDS, UNESCO, UNFPA, UNICEF, UN Women, WHO, and the World Bank.

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2. Using the AA-HA! Guidance

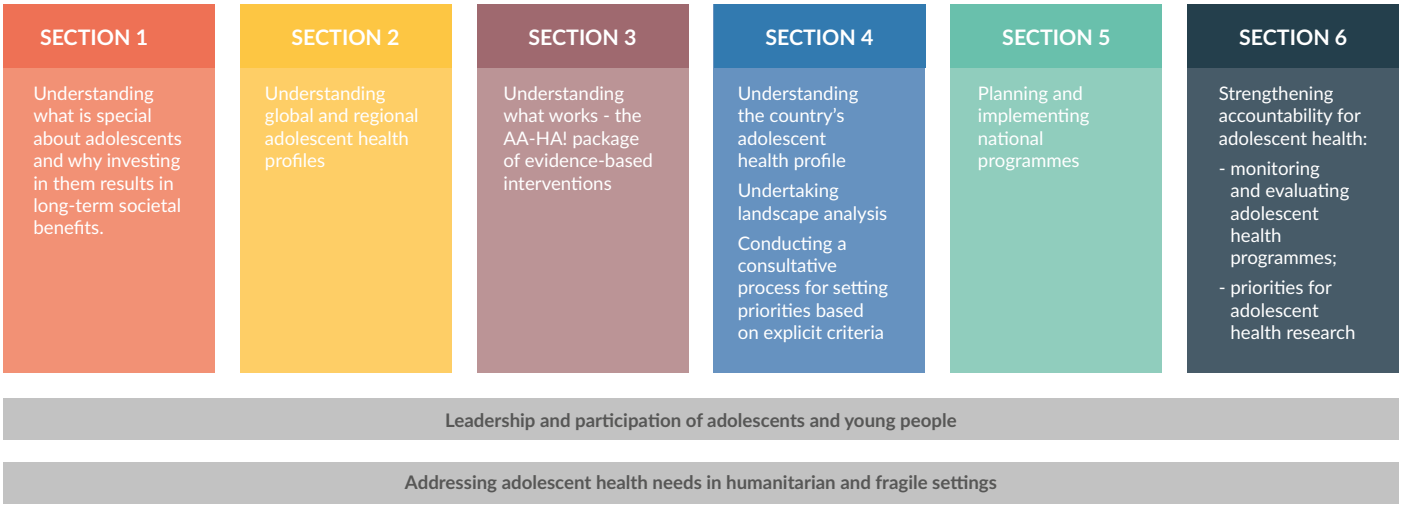
The primary audience for the AA-HA! guidance (2) is policy-makers and programme managers who are responsible for adolescent health programming in countries – both within the health sector and in other key sectors.

After a brief introduction which summarizes the main arguments for investing in adolescent health, the full reference document details the key steps in understanding a country's epidemiological profile; undertaking a landscape analysis to clarify what is already been done, and by whom; conducting a consultative process for setting priorities; and planning, implementing, monitoring and evaluating national adolescent health programmes. It ends with key research priorities (Figure 1).

It does not attempt to be a basic textbook on public health, but instead focuses on what is special about programming for adolescent health, and includes examples of how to involve adolescents and young people meaningfully in the different steps. More than 70 case studies illustrate that the suggestions given can be implemented – because they have been so already in a particular national or other large-scale programme.

This document provides a brief summary of the key content in the AA-HA! guidance (2). A comic book based on the key messages has also been written for young adolescents (3), and a brochure created to facilitate dissemination (4).

Figure 1. The systematic approach for the implementation of accelerated action for the health of adolescents (AA-HA!)



3. Why invest in adolescent health?

The 2030 Agenda for Sustainable Development cannot be achieved without investment in adolescent health and well-being. There are at least five arguments why investing in adolescent health is indispensable:

1. Adolescents have the fundamental right to health

Adolescents, like all people, have fundamental rights to life, development, the highest achievable standards of health, and access to health services. Yet they suffer a high burden of disease from preventable causes, mainly related to unintentional injuries; violence; sexual and reproductive health, including HIV; communicable diseases such as acute respiratory infections and diarrhoea; noncommunicable diseases, poor nutrition and lack of physical activity; mental health, substance use and self-harm (5).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2. Investments in adolescent health bring a triple dividend of health benefits (6):

- For adolescents now – adolescent health is immediately benefited by promotion of positive behaviours (e.g. good sleep habits and constructive forms of risk-taking, such as sport or drama) and by prevention, early detection and treatment of problems (e.g. substance use disorders, mental disorders, injuries and sexually transmitted infections).
- For adolescents' future lives – to help set a pattern of healthy lifestyles, and reduce morbidity, disability and premature mortality later in adulthood, support is needed to establish healthy behaviours in adolescence (e.g. diet, physical activity and, if sexually active, condom use) and reduce harmful exposures, conditions and behaviours (e.g. air pollution, obesity and alcohol and tobacco use).
- For the next generation – the health of future offspring can be protected by promoting emotional well-being and healthy practices in adolescence (e.g. managing and resolving conflicts, appropriate vaccinations and good nutrition) and preventing risk factors and burdens (e.g. lead or mercury exposure, interpersonal violence, female genital mutilation, substance use, early pregnancy and pregnancies in close succession).

Gains made through substantial investment in maternal and child health programmes over recent decades are at risk of being lost if there is insufficient investment in adolescent health programming today (7). Investment in adolescent health will build on earlier gains in young child health, and will sustain those investments.


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3. Investments in adolescent health reduce present and future health costs and enhance social capital (8).


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4. Adolescents are not simply old children or young adults; they have particular needs

Adolescence is one of the most rapidly changing, formative phases of human development. The range of determinants that influence human health take particular forms and have unique impacts in adolescence (Figure 2).

The rapid physical, cognitive, social, emotional and sexual development that takes place during adolescence demands special attention in national development policies, programmes and plans.

In 2015, an estimated 1.2 million adolescents died from largely preventable causes (9).

5. Adolescents bear a substantial proportion of global disease and injury burden

Adolescents are one sixth of the world's population (10) and account for 6% of the world's global burden of disease and injury (10); (11). In 2015, more than 1.2 million adolescents died.

Causes of death and disability-adjusted life years (DALYs) lost differ between younger (10-14 year old) and older (15-19 year old) adolescents and between males and females (Figures 3 and 4). Overall rates of death and DALYs lost are higher for males than females and are particularly high for older adolescent boys and young males (9); (11).

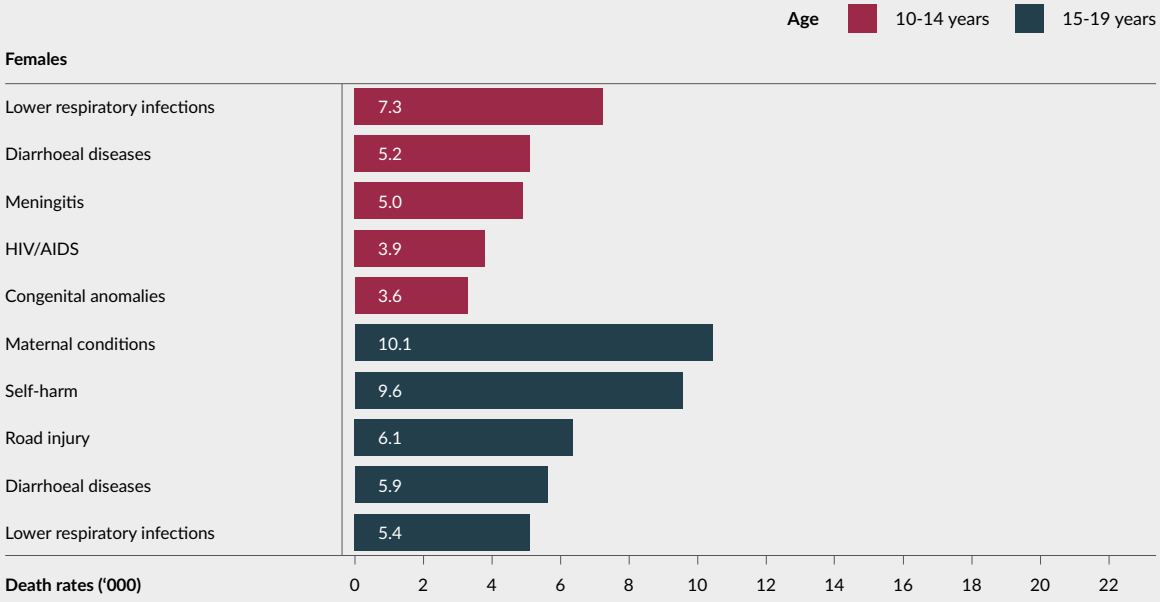
Some causes of death have a high ranking only among males (e.g. drowning) or females (e.g. maternal conditions), or among younger (e.g. lower respiratory infections) or older adolescents (e.g. interpersonal violence and self-harm) (Figure 3) (9).

Similarly, some causes of DALYs lost only have a particularly high ranking among males (e.g. road injury and drowning) or females (e.g. anxiety and maternal conditions), or among younger (e.g. lower respiratory infections) or older adolescents (self-harm and depressive disorders) (Figure 4) (11). These differences illustrate clearly that disaggregation of health information is important to identify and act upon the special needs of different sexes and age groups.

Figure 2. What is Special about Adolescents?

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

Figure 3. Estimated top five causes of adolescent death by sex and age, 2015



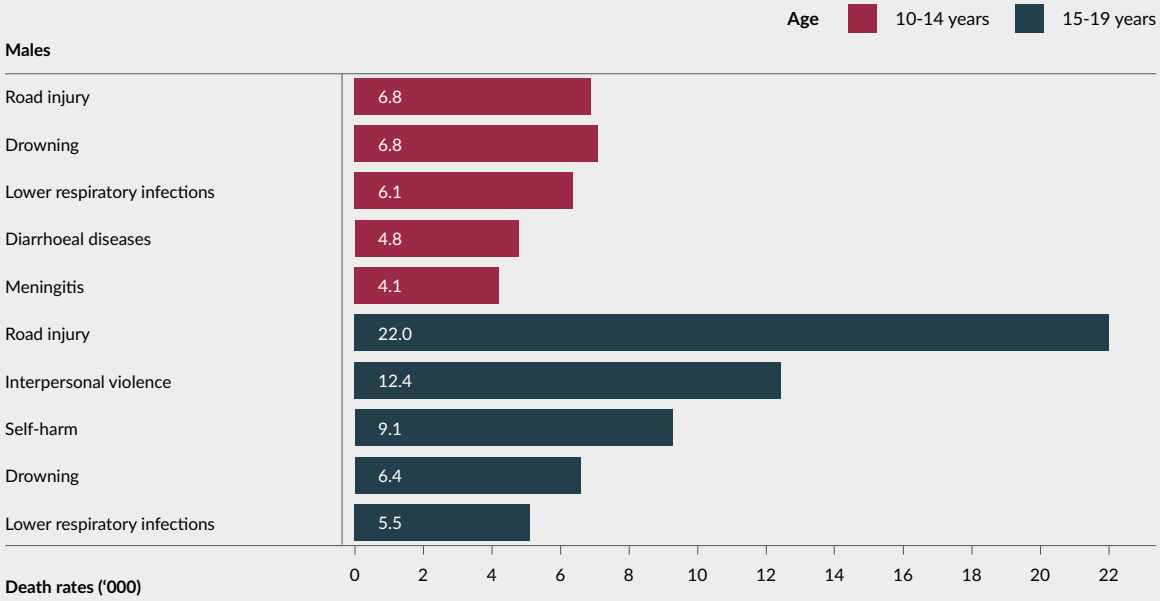
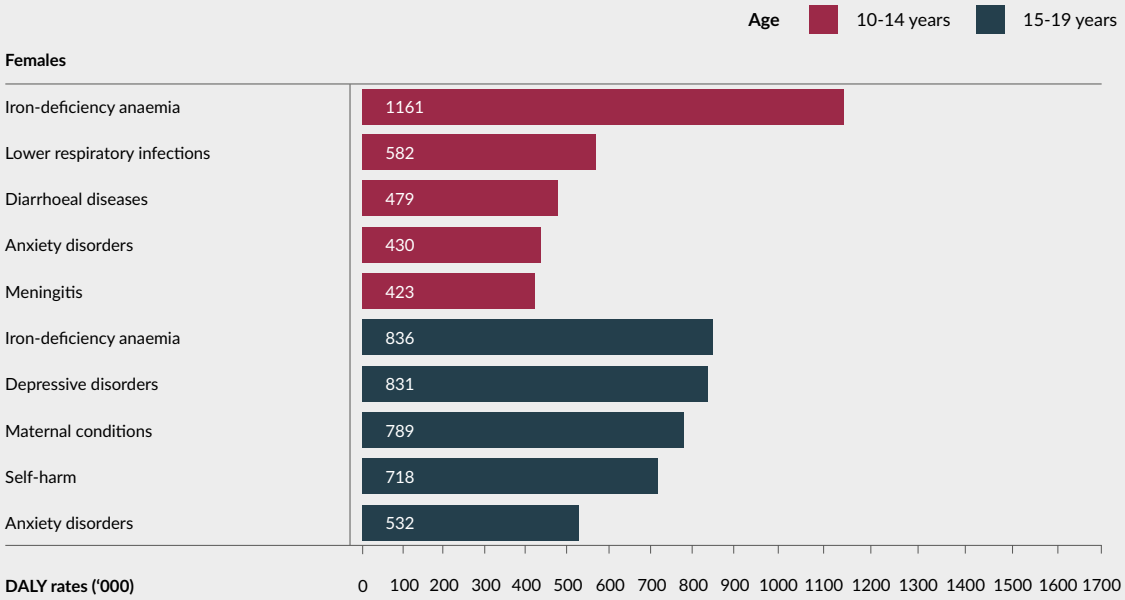
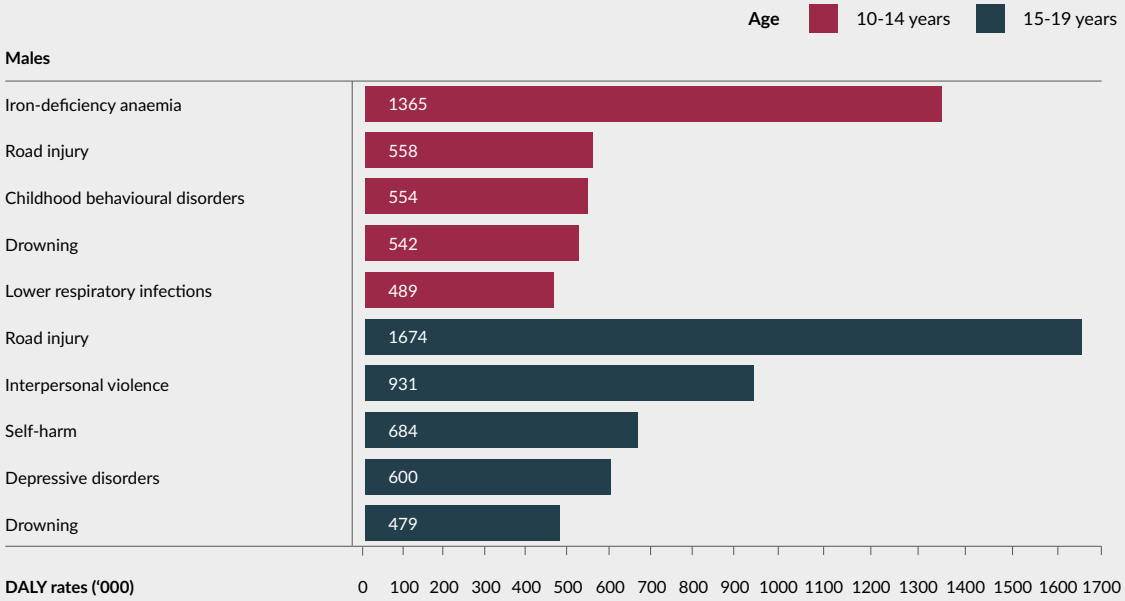


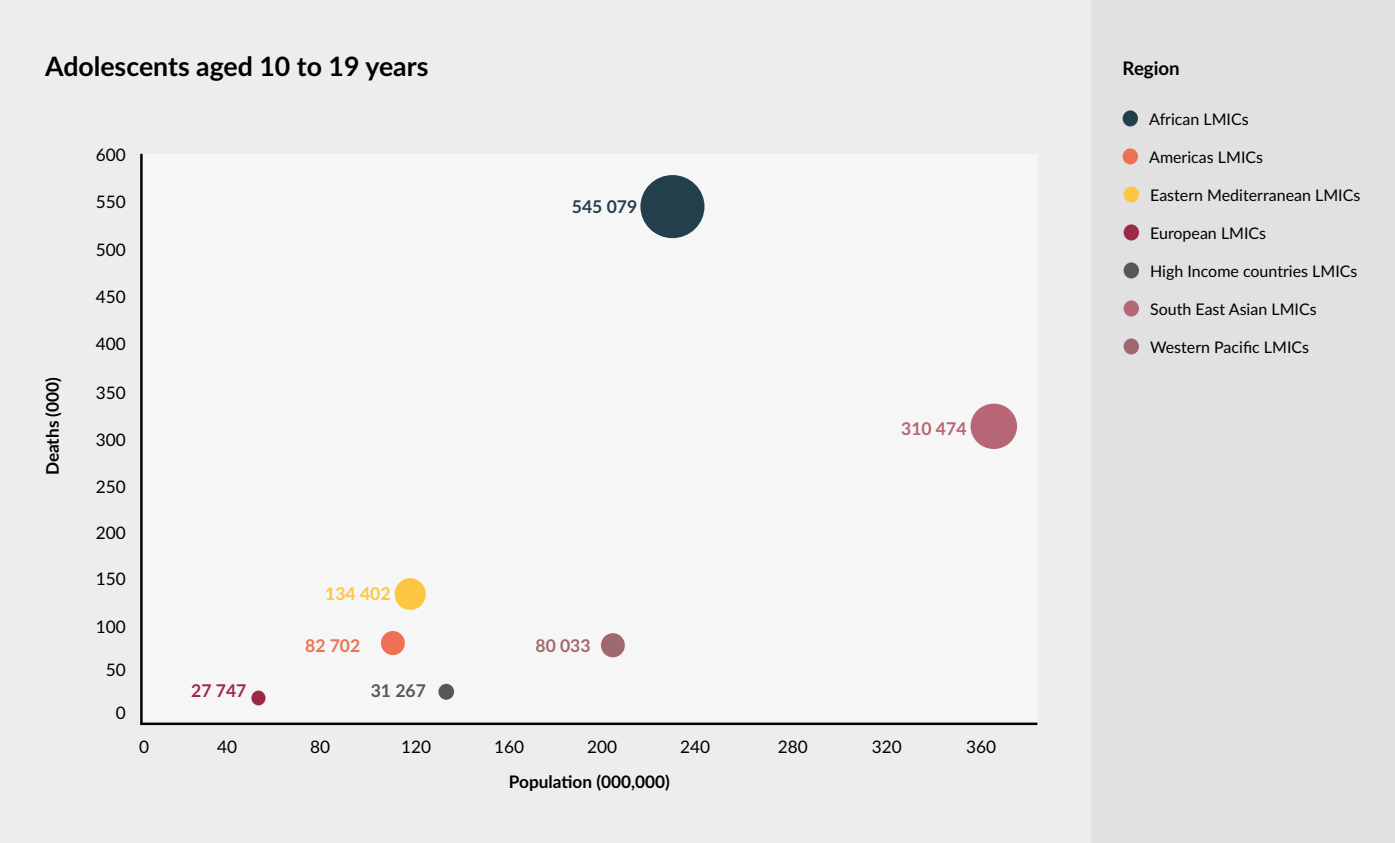
Figure 4. Estimated top five causes of adolescent disability-adjusted life years (DALYs) lost by sex and age, 2015.





Adolescent disease burdens vary greatly across the world. Figure 5 shows the distribution of the estimated 1.2 million adolescent deaths in 2015 by modified WHO region (9); (12). Nearly two-thirds of these deaths occurred in low- and middle-income countries (LMICs) in the African (45%) and South-East Asia (26%) regions. These regions have 19% and 30% of the world's adolescent population, respectively (2); (9); (12).

Figure 5. Estimated adolescent deaths by population size and modified WHO region, 2015.

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The top five estimated causes of death for each modified WHO region are shown in Figure 6. While some causes of adolescent mortality or morbidity have a great impact in most regions (e.g. road injury, lower respiratory infections, drowning and depressive disorders), the nature and relative impact of these and other adolescent burdens differ greatly within and between regions. For example, the leading causes of adolescent mortality are lower respiratory infections and diarrhoeal diseases in African LMICs, but are interpersonal violence in Americas LMICs, and collective violence and legal interventions in Eastern Mediterranean LMICs (9); (12).

Figure 6. Estimated top five causes of adolescent death by modified WHO region, 2015.

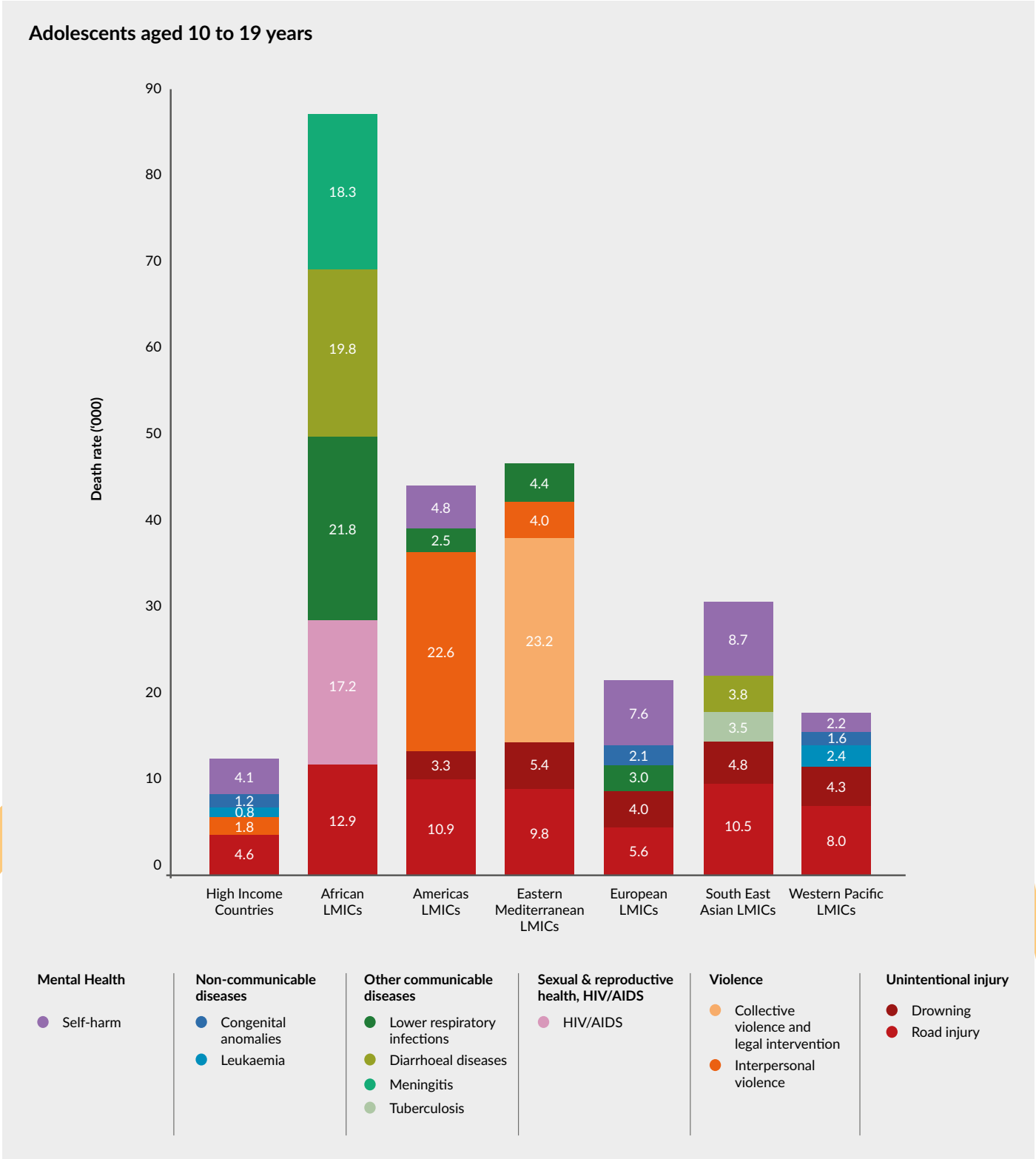
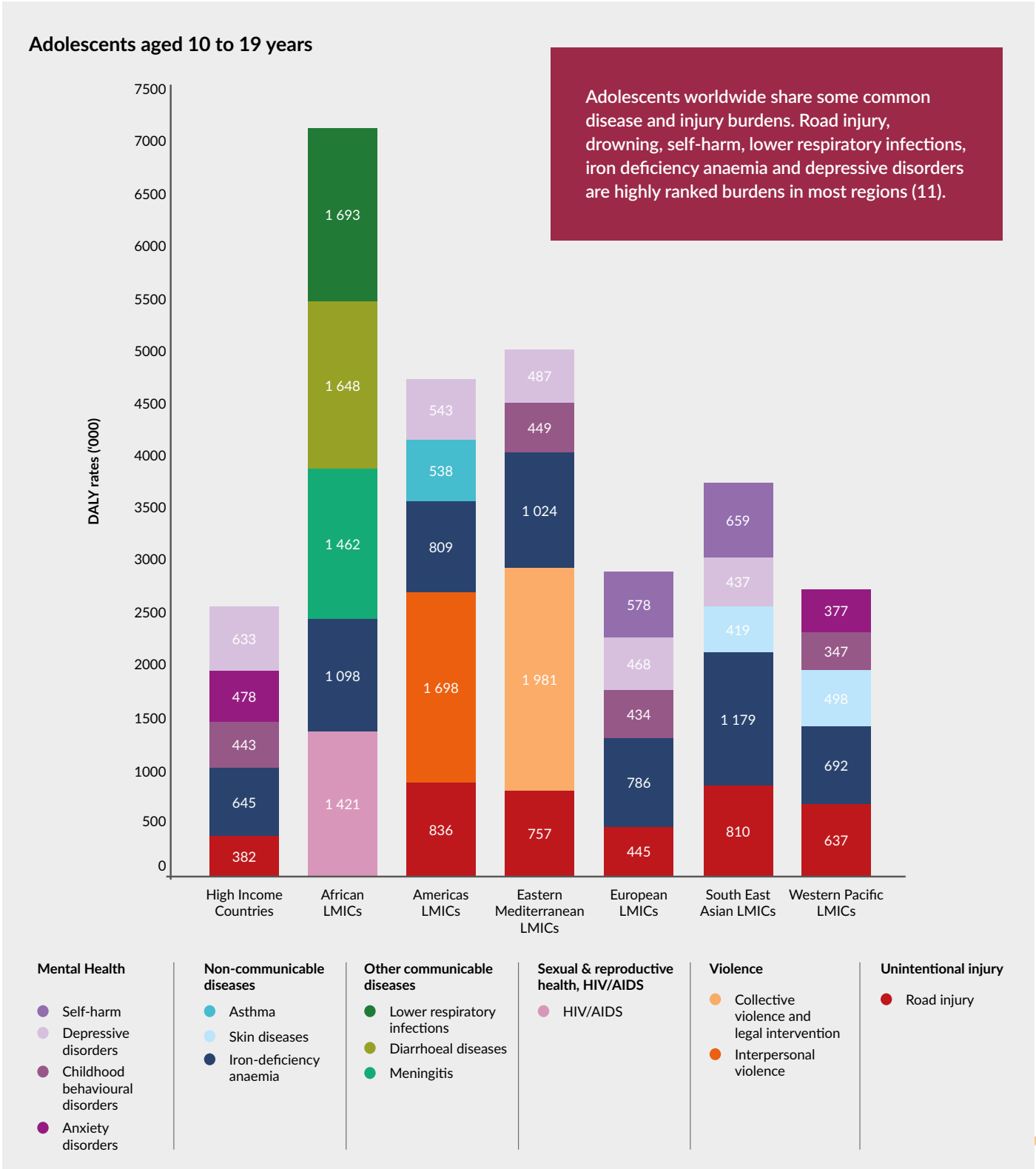


Figure 7 shows the top five estimated causes of DALYs lost for each modified WHO region. Iron deficiency anaemia, road injury and self-harm (including suicide) are common causes of DALYs across most regions (9); (11); (12). African LMICs remain heavily burdened by HIV/AIDS and other communicable diseases, while Eastern Mediterranean countries have a particularly high burden from collective violence and legal intervention. Americas LMICs have a high burden due to interpersonal violence and they share a highly ranked burden from skin diseases with LMICS in South-East Asia and the Western Pacific (11).

Figure 7. Estimated top five causes of adolescent disability-adjusted life years (DALYs) lost by Modified WHO Region, 2015.



Adolescence is also a period when many risk or protective behaviours start or are consolidated. Examples include diet and physical activity, substance use and sexual risk behaviours. These will have major effects on future adult health. For 10–14 year olds, unsafe water, unsafe sanitation and inadequate hand washing are major health risks for both boys and girls (13). For 15–19 year olds, health risk factors such as alcohol and tobacco use, unsafe sex and drug use also become very important, along with intimate partner violence and occupational hazards (13). Each government should evaluate its country's particular adolescent health needs before developing – or improving upon – adolescent health programmes (2).

National governments need to identify and address their adolescent health priorities, because:

- the nature, scale and impact of adolescent health needs are unique in each country; and
- all governments face resource constraints, so they must make difficult choices to ensure their adolescent health resources are used most effectively.

The AA-HA! guidance provides a systematic approach to prioritizing national health needs.

This includes:

- **a needs assessment to identify which conditions have the greatest impact on adolescent health and development;**
- **a landscape analysis of existing adolescent health programmes, policies, legislation, capacity and resources within the country; and**
- **priority setting that considers explicit criteria, including the needs of the most vulnerable groups.**

Within countries, it is important to consider which subpopulations experience higher exposure and vulnerability to health risks, lower access to health services, worse health outcomes and greater social consequences as a result of ill health. Inequities are often seen among groups that differ by sex, income, education and rural or urban residence (8); (14-16).

Particularly vulnerable adolescents include those:

- living with disabilities or chronic illnesses (e.g. sickle-cell anaemia or HIV);
- living in remote areas or caught up in social disruption from natural disasters or armed conflicts (e.g. refugees);
- stigmatized and marginalized because of sexual orientation, gender identity or ethnicity;
- institutionalized or exposed to domestic violence or substance abuse in the family;
- exploited and abused (e.g. girls working as domestic servants);
- married, or who migrate for work or education without family or social support;
- experience racial or ethnic discrimination;
- not in education, employment or training; and
- who do not have access to health services or social protection (e.g. poor urban and rural residents or homeless adolescents).

4. Act now!

Though there are important gaps in scientific evidence, many interventions to promote and protect adolescent health are proven to work. As a result, countries can take effective action now to promote and protect adolescent health. They should ensure that every adolescent has access to the 27 Global Strategy adolescent health interventions recommended by the Global Strategy for Women's, Children's and Adolescents' Health (Figure 8) and positive adolescent development interventions, especially in humanitarian and fragile settings (1).

Figure 8. AA-HA! adolescent evidence-based interventions at a glance

Positive development	Unintentional Injury	Violence	Sexual and reproduction health, including HIV
• Adolescent-friendly health services • Health-promoting schools • Improving hygiene and nutrition • Child online protection • e-health and m-health interventions for health education and the involvement of adolescents in their own care • Parenting interventions • Adolescent participation and interventions to promote competence, confidence, connection, character and caring	• Laws on drinking age, blood alcohol concentration, seat-belt and helmet wearing, graduated driver licencing • Traffic calming and safety measures • Pre-hospital and hospital care • Community campaigns and individual interventions to promote behavioural change related to safe driving and good laws to encourage behavioural change • Population, community-based and individual level drowning prevention measures • Assessment and management of adolescents who present with unintentional injury, including alcohol-related injury • Infrastructure design and improvement • Vehicle safety standards	INSPIRE strategies to preventing and responding to all forms of violence against children and adolescents: • Implementation and enforcement of laws: banning violent punishment, criminalizing sexual abuse and exploitation of children, prevent alcohol misuse, limit youth access to firearms and other weapons • Norms and values: changing adherence to restrictive and harmful gender and social norms, community mobilization programmes, bystander interventions • Safe environments: addressing "hotspots", interrupting the spread of violence, improving the built environment • Parent and caregiver support through home visits, community approaches and comprehensive programmes • Income and economic strengthening: cash transfers, group saving and loans, microfinance • Response and support services: screening and interventions, counselling and thera-peutic approaches, programmes for juvenile offenders, foster care interventions • Education and life skills: increasing school enrolment, safe and enabling school environment, life and social skills training	• Comprehensive sexuality education • Information, counselling and services for comprehensive sexual and reproductive health, including contraception • Prevention of and response to harmful practices, such as female genital mutilation and early and forced marriage • Pre-pregnancy, pregnancy, birth, post-pregnancy, abortion (where legal) and postabortion care, as relevant to adolescents • Prevention, detection and treatment of sexually transmitted and reproductive tract infections, including HIV and syphilis • Voluntary medical male circumcision (VMMC) in countries with generalized HIV epidemics • Comprehensive care of children (including adolescents) living with, or exposed to, HIV
Communicable diseases	**Non-communicable diseases, nutrition and physical activity**	**Mental health, substance abuse and self-harm**	**Conditions with particularly high priority in humanitarian and fragile settings**
• Prevention, detection and treatment of communicable diseases, including tuberculosis • Routine vaccinations, e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella, measles • Prevention and management of childhood illnesses, including malaria, pneumonia, meningitis and diarrhoea • Case management of meningitis	• Structural, environmental, organizational, community, interpersonal and individual level interventions to promote healthy behaviour (e.g. nutrition; physical activity; no tobacco, alcohol or drugs) • Prevention, detection and treatment of non-communicable diseases • Prevention, detection and management of anaemia, especially for adolescent girls; iron supplementation where appropriate • Treatment and rehabilitation of children with congenital abnormalities and disabilities	• Care for children with developmental delays • Responsive caregiving and stimulation • Psychosocial support and related services for adolescent mental health and well-being • Parent skills training, as appropriate, for managing behavioural disorders in adolescents • Structural, environmental, organizational, community, interpersonal and individual level interventions to prevent substance abuse • Detection and management of hazardous and harmful substance use • Structural, environmental, organizational, community, interpersonal and individual level interventions to prevent adolescent suicide • Management of self-harm and suicide risks	• Assess conditions and ensure adequate nutrition for adolescent population groups according to age, gender, weight, physical activity levels and other key factors • Ensure core health services to support adolescents with disabilities in an emergency • Medical screening of former child soldiers, and clinical management and community-based psychosocial support for survivors of sexual and/or gender-based violence • Implement a minimal initial sexual and reproductive health service package • Ensure safe access to and use and maintenance of toilets; materials and facilities for menstrual hygiene management and other intervention to improve water, sanitation and hygiene • Promote mental health through normal recreational activities for adolescents, re-start of formal or informal education, and involvement in concrete, purposeful common interest activities • Provide psychological first aid and first-line management of adolescent mental, neurological and substance-use conditions

5. Who is responsible?

Adolescent health is largely driven by determinants outside of the health sector (e.g. family and community norms, education, labour markets, economic policies, legislative and political systems, food systems and the built environment) (17). As a result, achieving optimal health and well-being for adolescents will require actions by multiple sectors and effective intersectoral coordination and collaboration (Figure 9). It will also require the active participation of adolescents themselves.

Figure 9. An overview of health and other sectors roles in programming for adolescent health

PROGRAMMING WITHIN THE HEALTH SECTOR FOR UNIVERSAL HEALTH COVERAGE		PROGRAMMING WITH OTHER SECTORS TO ADDRESS BROADER DETERMINANTS OF HEALTH		
Programming for adolescent- responsive health systems	Adolescent- specific programmes within the health sector	Programming for adolescent health in humanitarian and fragile settings	Programming for Adolescent Health in All Policies (AHiAP)	Intersectoral programmes
Programming for adolescent-responsive health systems Addresses health determinants for which the health sector has the primary responsibility (e.g. availability, accessibility and acceptability of health-care services). The health sector leads, but mobilizes and supports other sectors in contributing to health-sector objectives.		The health sector leads on health-sector interventions, but shares responsibility with other sectors within a well-defined multi-stakeholder coordination.	Other sectors have the primary responsibility to ensure that adolescents and adolescent health are given adequate attention. The health sector raises awareness, mobilizes and provides technical support to other sectors.	The health sector shares responsibility with other sectors through joint definition of objectives, planning and funding. Any sector may be given the primary coordination and monitoring role.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BOX 1

Adolescent Health in All Policies (AHiAP)

AHiAP is an approach to public policies across sectors that systematically takes into account the implications of decisions for adolescent health, avoids harmful effects and seeks synergies – in order to improve adolescent health and health equity (18); (19). It is a strategy that facilitates the formulation of adolescent-responsive public policies in all sectors, and not just within the health sector (20).

6. Adolescent participation and leadership

The AA-HA! guidance provides a multitude of examples from countries of various ways of involving adolescents in decision-making, and investing in their leadership capacity.

Countries should ensure that adolescents' expectations and perspectives are included in national programming processes. Adolescent leadership and participation should be institutionalized and actively supported during the design, implementation, monitoring and evaluation of adolescent health programmes (Box 2).

The meaningful involvement of young people in all aspects of their own, and their communities', development brings multiple benefits (2). From an **operational perspective**, adolescent participation contributes to better decisions and policies. It allows decision-makers to tap into adolescents' unique perspectives, knowledge and experiences, which brings a better understanding of their needs and problems and leads to better solutions.

Furthermore, respecting adolescents' views regarding their health care ensures that more adolescents will seek information and services and remain engaged in them.

From a **developmental perspective**, the engagement of adolescents enhances adolescent-adult relationships, develops adolescent leadership skills, motivation and self-esteem, and enables them to develop the competencies and the confidence they need to play an active, positive and pro-social role in society (21). All of this has an important positive influence on their social and emotional development (6).

From an **ethical and human rights perspective**, the right of adolescents to participate in decision-making is enshrined in the United Nations Convention on the Rights of the Child (22) and reinforced in the recent General Comment on the implementation of the rights of the child during adolescence (23), and is a way to promote health equity. The underlying causes of inequities are the unequal distribution of power, money and resources. Therefore, the involvement, empowerment and meaningful participation of all adolescents – including both adolescent boys and girls and the most vulnerable adolescents – constitutes one of the mechanisms to achieve equity (24).

BOX 2

Key areas for programming to ensure adolescent leadership and participation in health programming; selected examples.

(For the full list of key areas for programming, see Section 5 of the AA-HA! reference document (2)

- Ensure that national policy frameworks recognize the importance of the meaningful engagement of adolescents and youth.
- Establish structures and processes to institutionalize adolescent participation in dialogues about relevant areas of public policy, financing and programme implementation at the national, district and local levels.
- Build mechanisms for youth participation at the local level, including taking advantage of technological platforms.
- Train and mentor youth leaders to build their competencies to play an effective role in governance and accountability processes around their health and wellbeing.
- Build legal awareness and literacy among adolescents about their rights under the Convention on the Rights of the Child, and their legal entitlements.
- Put mechanisms and procedures in place to ensure adolescent participation in health services.
- Identify clearly the objectives of adolescent participation, and institutionalize the monitoring and evaluation of youth engagement with specific indicators.

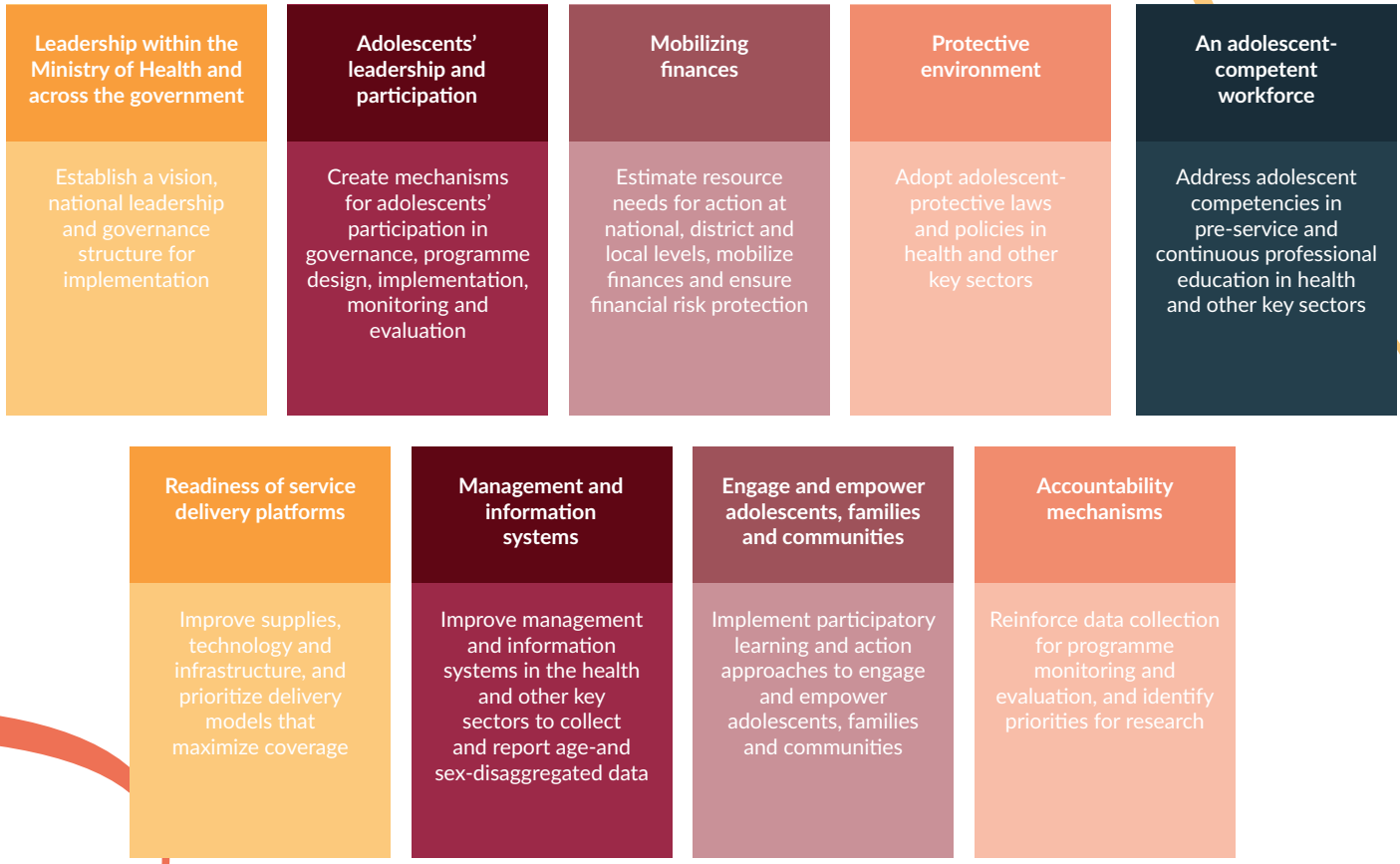
Sources: (6); (25).

7. Programming for universal health coverage and to address broader determinants of health

The AA-HA! guidance outlines key areas for programming to ensure that policies in key sectors – health; education; social protection; telecommunications; roads and transportation; housing and urban planning; energy; environment; and criminal justice – are formulated and implemented with due attention to the inclusion of evidence-based policies and interventions that will improve adolescent health. To support countries in programming for adolescent health, WHO has developed a logical framework for adolescent health programming that outlines common elements and key areas for programming.

The scope of adolescent health programming encompasses all the six major health areas covered in the Global AA-HA! guidance (see above). It is difficult therefore to have a blueprint for the specific elements in the design and implementation of adolescent health programmes. However, a unifying approach is possible (Figure 10).

Figure 10. Common elements of programming for adolescent health.



Leadership within the Ministry of Health and across the government

Leadership for adolescent health within the Ministry of Health, in each of the other key sectors and across the government, is an essential condition for successful programming (Box 3).

To achieve universal health coverage, health systems need to normalize the attention to adolescent-specific needs in all aspects of their work (2), and to mandate an adolescent health focal person in the Ministry of Health (1); (6).

To address broader determinants of health, strong leadership for adolescents is required at the highest level of the government to mandate collaboration between different arms of government working closely with communities, civil society, young people and the private sector. Countries may consider establishing a national-level mechanism, or use existing platforms, to oversee and coordinate efforts for adolescent health and wellbeing across sectors and government ministries.

BOX 3

Key areas for programming to ensure leadership within the Ministry of Health and across government; selected examples.

(For the full list of key areas for programming, see Section 5 of the AA-HA! reference document (2)

- Establish a national-level mechanism, or use existing platforms, to oversee and coordinate efforts for adolescent health and well-being across sectors and government ministries.
- Mandate an adolescent health focal person in the Ministry of Health to work across health departments and programmes and to plan and manage inter-sectoral action.
- Build national and subnational (e.g. district-level) political and administrative capacity and leadership for adolescent health in areas such as using data for decision-making, advocacy, negotiation, budgeting, building consensus, planning and programme management (monitor, review and act), collaborating across sectors, mobilizing resources and ensuring accountability.

Sources: (1); (6).

Financing adolescent health priorities in national health plans, and ensuring financial risk protection for adolescents

The way that health services are financed is central to progress towards universal health coverage.

For adolescents, three aspects of financing are crucial (26):

- maximizing the number of adolescents covered by an effective prepaid pooling arrangement, which can take the form, for example, of an insurance programme or provision of free access to facilities that are financed by prepaid pooled funds;
- reducing or removing out-of-pocket payments at the point of use; and
- expanding the range of services covered by the prepaid pooling arrangement to include all the services in the country's package for adolescents.

Expanding resource allocation for adolescent health priorities in national health plans

A case for investment in adolescent health will be much stronger if associated costs are estimated. National policies and strategies that address adolescent health should therefore be accompanied by fully costed plans that include estimates of the resources needed to implement the interventions that have been prioritized, and the associated programme costs.

National strategic health plans provide a platform for stakeholders to agree strategic directions and priorities for the health plan for the short and medium term (Box 4). When the Ministry of Health engages in negotiations with the Ministry of Finance, it should make a strong case for investment in adolescent health based on the triple dividend argument of benefits now, into future adult life and for the next generation (see above) (6); (26). A discussion of financing arrangements, such as exemptions from user fees for adolescents, requires data and supporting arguments for the resources needed to support the proposed changes in financing policy, and what it would bring in terms of benefits.

BOX 4

Key areas for programming to ensure financing for adolescent health priorities in national health plans, and financial risk protection of adolescents; selected examples.

(For the full list of key areas for programming, see Section 5 of the AA-HA! reference document (2)

- Define the required package of health information, counselling, diagnostic, treatment and care services to be provided to all adolescents.
- Estimate resource needs for the implementation of the priority package of interventions and associated programme costs, using tools such as the OneHealth Tool (27).
- Prepare a strategic and compelling plan for investment in adolescent health based on the triple dividend argument.
- Build the capacity of national and district project managers to leverage external funds for adolescent health priorities using opportunities provided by the Global Financing Facility and strategic investments by the Global Fund and GAVI the Vaccine Alliance, among others.
- Build the agency and capacity of district and community managers to address adolescent health priorities when making local adjustments to central budgets.
- Design and implement measures for adolescent financial risk protection (e.g. waivers, vouchers and exemptions or reduced co-payments).
- Provide incentives that motivate health workers to implement quality interventions that are essential for adolescent health and development, e.g. through pay-for-performance mechanisms.

Sources: (25); (27-30).

Designing laws and policies that treat adolescents' rights to health, protection and autonomy as universal, indivisible and interrelated

Laws and policies should protect, promote and fulfil adolescents' right to health. Legal and regulatory frameworks should be based on internationally recognized and accepted human rights principles and standards (5); (31). Adolescent-protective laws and policies require, among other things, ensuring that the services that adolescents need are available and accessible to them, without discrimination (26); (32).

Adolescents are in need of protective policies. Parents or legal guardians, health and social workers, teachers and other adults have key roles to play in ensuring a safety net for them. However, this should not mean that adolescents are seen as being incapable of making decisions about their lives. Protection and autonomy may seem to be conflicting principles – because protective measures tend to restrict adolescents' autonomy – but in fact they can be balanced and are mutually reinforcing (23). Fostering autonomy, for example by empowering adolescents to access health services, is a protective measure, since timely access to services could protect them from potential harm.

BOX 5

Key areas for programming to ensure adolescent-protective laws and policies; selected examples.

(For the full list of key areas for programming, see Section 5 of the AA-HA! reference document (2))

- Assess the legal and regulatory frameworks that mediate adolescents' access to services for compliance with internationally recognized and accepted human rights principles and standards.
- Enforce policies to redress inequalities and discriminatory practices in adolescents' access to services.
- Establish procedures to be followed in health facilities to ensure that confidentiality and privacy are respected.
- Review national laws and policies to indicate situations, clearly and unambiguously, when confidentiality may be breached, with whom and for what reasons, and establish standard operating procedures for such situations.
- Determine appropriate and acceptable age limits when adolescents may give consent or refuse health treatment or services without parental or guardian involvement.
- Adopt flexible policies to allow specific groups of adolescents to be considered "mature minors".
- Remove the need for parental or guardian consent when an adolescent is seeking counselling and advice.
- Remove the need for mandatory third-party (e.g. parental, guardian or spousal) authorization or notification in the provision of sexual and reproductive health services, including contraceptive information and services.
- Adopt policies to protect the rights of adolescents with disabilities.
- Ensure elimination of harmful practices inflicted on young people without consent, including female genital mutilation and early and/or forced marriage.

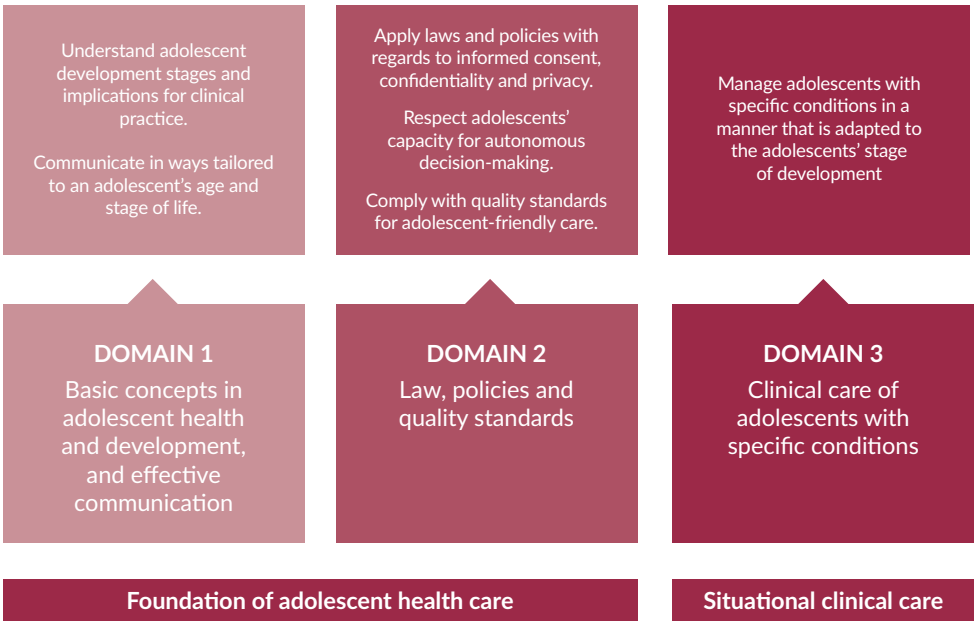
Sources: (5); (23); (29); (32-34).

An adolescent-competent workforce

To support countries in building an adolescent-competent workforce, WHO developed Core Competencies in Adolescent Health and Development for Primary Care Providers, which includes an implementation guide and a tool to assess the adolescent health and development component in pre-service education and to develop recommendations (35).

Adolescents are not simply older children or younger adults. The complex interplay of individual, interpersonal, community, organizational, environmental and structural factors make adolescents unique in the ways that they understand information, which channels of information influence their behaviours, and in how they think about the future and make decisions in the present (27). All health workers who are in places that adolescents visit (e.g. hospitals, primary care facilities and pharmacies) should develop their competencies (i.e. knowledge, skills and attitudes) in adolescent-responsive health care, to be able to respond to their specific needs (Figure 11).

Figure 11. Domains for core competencies in adolescent health care



BOX 6

Key areas for programming to ensure an adolescent-competent workforce; selected examples.

(For the full list of key areas for programming, see Section 5 of the AA-HA! reference document (2))

- Define core competencies in adolescent health and development in line with WHO Core Competencies for Adolescent Health and Development for Primary Care Providers (36).
- Create and implement competency-based training programmes in pre-service and continuing professional education.
- Establish a mechanism to consult health-care providers on their training and education needs in adolescent health care, and conduct capacity-building activities at national and district levels that are aligned with reported needs.
- Develop and review information and training materials, practice guidelines and other tools to support decision-making in adolescent health care.
- Strengthen the capacity of community health workers in reaching adolescents.
- Set up a system for supportive supervision of adolescent health care, and provide collaborative learning opportunities as a key strategy to improve providers' performance.

Sources: (29); (32); (36).

Quality service delivery with high coverage

WHO and UNAIDS have developed the Global standards to improve quality of health-care services for adolescents to support countries in setting national standards to minimize variability and ensure a minimal required level of quality to protect adolescents' rights in health care (32). The document includes detailed guidance on facility, district and national level actions necessary to support the implementation of the Global standards, and a full set of quality and coverage measurement tools to support countries in assessing progress towards implementation of the standards.

Evidence from high-, middle- and low-income countries shows that adolescents experience many barriers to receiving quality health care, and that services for adolescents are often fragmented, poorly coordinated and uneven in quality (26). Recognizing the problems, many countries have moved towards a standards-driven approach to improve quality of care for adolescents, although few actually measure progress towards achieving these standards.

A critical consideration in national adolescent health programming is integration of services at the delivery level. For example, integrating treatment of the presenting complaint with a broader assessment using the HEADSSS checklist (home, education/employment, eating, activity, drugs, sexuality, safety, suicidal thinking and depression status) is an opportunity to provide a context for anticipatory guidance and preventive interventions (37).

BOX 7

Key areas for programming to ensure quality service delivery and service delivery platforms that maximize coverage; selected examples.

(For the full list of key areas for programming, see Section 5 of the AA-HA! reference document (2))

- Develop and implement national quality standards and monitoring systems in line with the WHO and UNAIDS Global Standards for Quality Health-Care Services for Adolescents (32).
- Implement e-standards to automate the processes of data collection and analysis, and to improve adolescent participation in providing feedback to facilities by using information technology.
- Establish local, subnational and national learning platforms for quality improvement.
- Improve primary- and referral-level care capacity to deliver integrated, adolescent-centred services (e.g. train providers in conducting a comprehensive health assessment in an adolescent).
- Strengthen school health services (school-based and school-linked) to facilitate adolescents' access to preventive services and to promptly manage any health problems detected.
- Engage community health workers in reaching adolescents, especially those out of school, with health education and services.
- Establish mechanisms for formal engagement of nongovernmental organizations in service delivery on behalf of the government to strengthen community-based platforms for service delivery, and to reach underserved populations of adolescents.
- Explore the potential for information and service delivery to adolescents through use of social and digital media.

Sources: (32); (38).

Age- and sex-disaggregated data

National health management and information systems rarely capture data specific to adolescents. Even when this does occur at the facility level, the data are often aggregated across age groups as they move up from facility to district or national level (25); (32). Data are typically compiled in ways that obscure adolescents' particular experiences; for example, through the use of 5–14 year and 15–49 year age bands.

Furthermore, data on young adolescents (10–14 years) are mostly available from school-based data-collection systems with the potential for bias where absenteeism is high or school retention is low. Programmes should review all national systems for health-data collection and find ways to incorporate a focus on adolescents, including on young adolescents and those out of school. Ideally, all data should be disaggregated by sex and five-year age bands for the first 25 years of life.

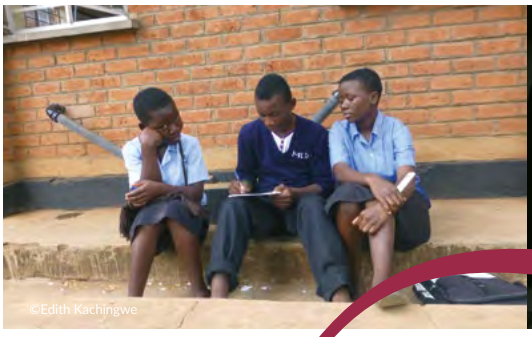
BOX 8

Key areas for programming to ensure age- and sex-disaggregated data in health management and information systems; selected examples.

(For the full list of key areas for programming, see Section 5 of the AA-HA! reference document (2))

- Improve the capacity of national and subnational statistics agencies to report regularly on the health, development and wellbeing of adolescents, disaggregated by age and sex.
- Implement participatory monitoring approaches to engage adolescents themselves in designing monitoring and evaluation systems, to capture the user perspective.
- Ensure that facility, district and national data collection and reporting forms allow for an explicit focus on adolescents (including young adolescents), cause-specific utilization of services, and quality of care.
- Develop national capacity to conduct standardized surveys on key adolescent behaviours and social determinants, and conduct such surveys at regular intervals.
- Develop national capacity to conduct standardized surveys to monitor inputs, processes and outputs within national school health programmes.
- Strengthen the availability of disaggregated adolescent health-related data and information to expose inequities.
- Strengthen capacity to conduct qualitative research to understand the underlying causes of trends.
- Synthesize and disseminate the evidence base for action.

Sources: (25); (32).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Institutionalizing adolescent-specific programmes

To accelerate progress towards universal health coverage, countries may consider institutionalizing national adolescent health programmes within the health sector, with a broad scope across health priorities (Box 2).

BOX 9

Features of an institutionalized adolescent-health programme

The common features of institutionalized programmes are:

- having policy statements to support programme efforts;
- being a line item in a permanent health or education departmental budget;
- having a place in an organization chart;
- having permanent staff assigned to specific programme roles (e.g. national, subnational and local coordinators);
- having descriptions that include prevention functions and level of effort;
- having facilities and equipment for programme operations; and
- developing an institutional memory for important agreements and understandings.

Source: (39).

Renewed attention to school health programmes is needed and is a priority for intersectoral action on adolescent health. Every school should become a health-promoting school (4); (39). Countries that do not have an institutionalized national school health programme should consider establishing one, and countries that do have such programmes should continuously improve them to ensure that they align with the evidence base on effective interventions and emerging priorities.

The AA-HA! guidance contains 75 case studies from countries on programmes and programming for adolescent health, including programmes within the health sector and inter-sectoral programmes.

BOX 10

Priorities for inter-sectoral programmes; key areas for programming.

(For the full list of key areas for programming, see Section 5 of the AA-HA! reference document (2))

- Establish, or critically review, school health programmes to address priorities (e.g. noncommunicable diseases, sexual and reproductive health, communicable diseases and violence) in an integrated way.
- Plan interventions across the six programme components recommended by the WHO Health Promoting Schools Framework.
- Establish programmes to improve the nutritional status of adolescent girls.
- Implement programmes to prevent youth violence.
- Implement programmes to prevent early pregnancy.
- Implement national drug prevention programmes in early and late adolescence in accordance with the International Standards on Drug Use Prevention (40).
- Implement multisectoral programmes to reduce youth suicide rates.

Sources: (25); (29); (41-44).

The art of working together

The problems that require inter-sectoral action are usually the most complex ones (e.g. adolescent pregnancy, youth violence, injuries and suicide). In many settings, the idea that such complex problems can be prevented is likely to be new. The necessary human and institutional foundations for inter-sectoral action must therefore be built before establishing a formal inter-sectoral programme (2); (41). This can be done systematically (Box 11).

BOX 11

Planning and managing an inter-sectoral programme

For more details on practical considerations in planning and managing an inter-sectoral programme see Section 5 of the AA-HA! reference document (2).

- **Raise awareness of the extent of the problem, and that prevention is possible.**
- **Clarify the policy framework that mandates or enables inter-sectoral action for the issue at stake.**
- **Invest in consulting with different sectors and in establishing a shared vision among key stakeholders.**
- **Be aware of common barriers to inter-sectoral action, and take anticipatory remedial actions.**
- **Establish a formal partnership with clear governance structure and a mandate from the highest level of the government, and strong representation of adolescents and the community.**
- **Consider an independent advisory group to ensure independent scrutiny of progress.**
- **Invest early in organizational capability to** build the capacity of a wide variety of health professionals, programme administrators and policy-makers to assist them in the development of local plans, service delivery and research.
- **Provide guidance materials** and manuals to support local implementation and to facilitate fidelity in programme implementation.
- **Ensure discretionary funding for national, subnational and local activities.** Consider conditional allocation of implementation grants and contracts to local areas that is subject to conditions, such as appointing local coordinators and developing local plans.
- **Create a mechanism for review** informed by systematic collection of data through the information system.
- **Plan for long-term sustainability from the outset.** The WHO guide, Beginning With the End in Mind: Planning Pilot Projects and Other Programmatic Research for Successful Scaling up (45), contains 12 recommendations on how to design pilot projects with scaling up in mind.

Sources: (26); (41); (43); (45).

8. Addressing adolescent health needs in humanitarian and fragile settings

Adolescent health needs intensify in humanitarian and fragile settings, including from burdens related to: malnutrition; disability; unintentional injury; violence; sexual and reproductive health needs (e.g. early pregnancy, HIV and other STIs, and unsafe abortion); water, sanitation and related health needs (e.g. menstrual hygiene management); and mental health (1); (46); (47); (48); (49).

Adolescents who are especially vulnerable in humanitarian and fragile settings include those who are: young (10–14 years); disabled; members of ethnic or religious minorities; child soldiers; other children associated with fighting forces; girl mothers; orphans; heads of households; survivors of sexual violence, trafficked or subjected to other forms of gender-based violence; engaged in transactional sex; in same-sex sexual relationships; or HIV-positive (50).

BOX 12

Key areas for programming to address adolescent health in humanitarian and fragile settings; selected examples.

For the full list of key areas for programming, see Box A5.6 in Annex 5 of the AA-HA! reference document (2).

- Ensure that policies are in place to protect girls and boys from child labour and from exploitation and abuse by humanitarian workers.
- Put in place specific protection measures for unaccompanied minors, orphans and other vulnerable children.
- Ensure that programmes address the complex relationship between fragility and child marriage.
- Ensure that policies and practices in humanitarian and fragile settings respect adolescents' right to dignity, best interests, safety, autonomy and self-determination.
- Put in place policies for free access to essential interventions and services across sectors (e.g. health services, learning and schooling), including the basic package of health services for all adolescents, and enact policies to promote inclusion.
- Build humanitarian workers' and careers' capacities in adolescent-centred approaches and the principles of confidentiality, safety and security, respect and non-discrimination.
- Establish, as appropriate, adolescent- and girl-friendly spaces as a first response to adolescent needs for protection, psychosocial wellbeing and nonformal education.
- Ensure safe access to and use and maintenance of toilets; and materials and facilities for menstrual hygiene management.

Sources: (1); (51-59)

9. Accountability mechanisms, innovation and research

Monitoring and evaluation of national programmes

Once priorities are agreed, planning for programme implementation can begin. An important part of programme planning is monitoring and evaluation to measure progress, identify challenges and improve results. Monitoring is the systematic collection of data to check on the progress of a programme (60). It aims to answer the question: are we doing what we planned to do?

Setting indicators for monitoring can help identify which actions and resources are needed to achieve a programme's milestones and targets within the timeframe set for the programme (60). Monitoring is part of a project/programme cycle that allows for changes to be made to the programme plan in response to delays or unforeseen events (61).

The AA-HA! guidance summarizes the particular monitoring and evaluation needs of adolescent health programmes and the indicators and monitoring framework that have been agreed for the Global Strategy for Women's, Children's and Adolescents' Health (2016–2030) (1). It also stresses the importance of monitoring indicators of programme inputs, processes and outputs to achieve the targets of the Sustainable Development Goals and the Global Strategy. (1)

Evaluations should be an integral part of programme planning and should be included in the initial programme plan so that adequate budget is allocated for them. Evaluation planning also helps clarify the specific goals and targets of the programme, making it easier to anticipate and avoid the challenges that may otherwise derail the programme. Findings and recommendations from the programme evaluation should feed directly and promptly into programme re-planning and priority setting, forming another part of the project/programme cycle that incorporates the learning that comes from implementing programmes in different settings and with real-life challenges.

Research and innovation

WHO recently conducted two global research priority-setting exercises to help countries prioritize their research investments for adolescent health (62); (63). Both exercises showed that research priorities have shifted away from basic questions on the prevalence of specific health conditions and towards questions about how best to scale-up existing interventions and test the effectiveness of new ones.

10. Conclusion

This is an exciting time for adolescent health. Many countries have either taken steps to implement comprehensive adolescent health programmes or are planning to do so.

Act now, No excuses!

Building on the momentum created by the SDGs and the Global Strategy, the AA-HA! guidance provides technical advice to policy-makers and programme managers as they respond to the health needs of adolescents in their countries.

Led by WHO, this guidance document was developed in consultation with adolescents and young people, Member States, United Nations agencies and civil society organizations and other partners, and is endorsed by the Every Woman Every Child (EWEC) initiative, the Partnership for Maternal, Newborn & Child Health (PMNCH), UNAIDS, UNESCO, UNFPA, UNICEF, UN Women, WHO, and the World Bank.

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11. References

1. EWEC. The global strategy for women's, children's and adolescents' health (2016–2030). New York; 2015. (http://www.who.int/pmnch/media/events/2015/gs_2016_30.pdf).
2. WHO. Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation. Geneva; 2017.
3. WHO. Akilah and Carlos' big day of discovery. Geneva; 2017.
4. WHO. Apply AA-HA! together. Global accelerated action for the health of adolescents (AA-HA!): guidance to support country implementation. WHO brochure. Geneva; 2017.
5. WHO. Reproductive, maternal, newborn and child health and human rights: a toolbox for examining laws, regulations and policies. Geneva; 2014. (http://apps.who.int/iris/bitstream/10665/126383/1/9789241507424_eng.pdf).
6. Patton GC, Sawyer SM, Santelli JS, Ross DA, Afifi R, Allen NB et al. Our future: a Lancet commission on adolescent health and wellbeing. Lancet. 2016;387(10036):2423-78. (http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(16)00579-1/fulltext).
7. Resnick MD, Catalano RF, Sawyer SM, Viner R, Patton GC. Seizing the opportunities of adolescent health. Lancet. 2012;379(9826):1564-7. (http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(12)60472-3.pdf).
8. UNFPA. The case for investing in young people as part of a national poverty reduction strategy. New York; 2010. (http://www.unfpa.org/publications/case-investing-young-people).
9. WHO. Global health estimates 2015: deaths by cause, age, sex, by country and by region, 2000–2015 Geneva; 2016 (http://www.who.int/healthinfo/global_burden_disease/estimates/en/index1.html).
10. UNICEF. The state of the world's children 2011. Adolescence – an age of opportunity. New York; 2011. (https://www.unicef.org/sowc2011/).
11. WHO. Global health estimates 2015: DALYs by cause, age, sex, by country and by region, 2000–2015 Geneva; 2016. (http://www.who.int/healthinfo/global_burden_disease/estimates/en/index2.html).
12. United Nations General Assembly A/RES/70/1. Transforming our world: the 2030 agenda for sustainable development. New York; 2015. (http://unctad.org/meetings/en/SessionalDocuments/ares70d1_en.pdf).
13. Mokdad AH, Forouzanfar MH, Daoud F, Mokdad AA, El Bcheraoui C, Moradi-Lakeh M, et al. Global burden of diseases, injuries, and risk factors for young people's health during 1990–2013: a systematic analysis for the global burden of disease study 2013. Lancet. 2016;387(10036):2383-401. (http://www.sciencedirect.com/science/article/pii/S0140673616006486).
14. Sonenstein FL. Introducing the well-being of adolescents in vulnerable environments study: methods and findings. J Adolesc Health. 2014;55(6 Suppl):S1-3. (https://www.ncbi.nlm.nih.gov/pubmed/25453997).
15. WHO, Johns Hopkins Bloomberg School of Public Health, UNFPA. The global early adolescent study: an exploration of the evolving nature of gender norms and social relations 10-14 years: a critical age. (http://aphrc.org/wp-content/uploads/2015/04/GEAS-March-2015.pdf).
16. WHO. Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook. Geneva; 2016. (http://apps.who.int/iris/bitstream/10665/250442/1/9789241511391-eng.pdf?ua=1)
17. WHO. 2015 Every woman, every child, every adolescent: achievements and prospects. The final report of the independent expert review group on information and accountability for women's and children's health. Geneva; 2015. (http://www.who.int/woman_child_accountability/ierg/reports/2015/iERG2015-ExecutiveSummary-EN.pdf?ua=1).
18. WHO. Practising a health in all policies approach: lessons for universal health coverage and health equity: a policy briefing for ministries of health based on experiences from Africa, South-East Asia and the Western Pacific. Geneva; 2013. (http://apps.who.int/iris/bitstream/10665/105529/1/9789241506632_eng.pdf?ua=1&ua=1).
19. 67th World Health Assembly. Contributing to social and economic development: sustainable action across sectors to improve health and health equity. 24 May 2014. Agenda item 14.6. (http://apps.who.int/gb/ebwha/pdf_files/wha67/a67_r12-en.pdf).
20. WHO. Demonstrating a health in all policies analytic framework for learning from experiences: based on literature reviews from Africa, South-East Asia and the Western Pacific. Geneva; 2013. (http://apps.who.int/iris/bitstream/10665/104083/1/9789241506274_eng.pdf).
21. Asker S, Gero A. The role of child and youth participation in development effectiveness: a literature review. Surry Hills: University of Technology and Child Fund Australia; 2012. (https://www.unicef.org/adolescence/cypguide/files/role_of_child_and_youth_participation_in_development_effectiveness.pdf).
22. OHCHR. Convention on the rights of the child. New York; 1989. (http://www.ohchr.org/EN/ProfessionalInterest/Pages/CRC.aspx).
23. United Nations Committee on the Rights of the Child. General comment No. 20 (2016) on the implementation of the rights of the child during adolescence; CRC/C/GC/20. (http://www.refworld.org/docid/589dad3d4.html).
24. WHO. Gender. In: WHO gender, equity and human rights [website]. (http://www.who.int/gender-equity-rights/understanding/gender-definition/en/).

25. EWEC, WHO. Operational framework for the Global Strategy for Women's, Children's and Adolescents' Health. New York; 2016. (http://www.who.int/life-course/partners/global-strategy/ewec-operational-framework/en/).
26. WHO. Health for the world's adolescents a second chance in the second decade: Summary. Geneva; 2014. (http://apps.who.int/adolescent/second-decade/files/1612_mncah_hwa_executive_summary.pdf).
27. WHO. OneHealth Tool: supporting integrated strategic health planning, costing and health impact analysis. Geneva; 2013. (http://www.who.int/choice/onehealthtool/onehealth_tool_supporting_integrated_strategic_health_planning.pdf)
28. Waddington C, Sambo C. Financing health care for adolescents: a necessary part of universal health coverage. Bull World Health Organ. 2015;93(1):57-9. (https://www.ncbi.nlm.nih.gov/pmc/articles/pmc4271683/pdf/blt.14.139741.pdf).
29. WHO. Health for the world's adolescents: a second chance in the second decade. In: Global Health Observatory visualizations [website]. (http://apps.who.int/gho/data/view.wrapper.MortAdov?lang=en&menu=hide) accessed 14 March 2017.
30. WHO. Public health agencies and cash transfer programmes: making the case for greater involvement. Geneva; 2011.(http://www.who.int/iris/handle/10665/44797).
31. Partnership for Maternal, Newborn & Child Health and WHO. A policy guide for implementing essential interventions for reproductive, maternal, newborn and child health (RMNCH): a multisectoral policy compendium for RMNCH. Geneva; 2014. (http://www.who.int/pmnch/knowledge/publications/policy_compendium.pdf).
32. WHO, UNAIDS. Global standards for quality health-care services for adolescents: a guide to implement a standards-driven approach to improve the quality of health care services for adolescents. Volume 2: implementation guide. Geneva; 2015. (http://apps.who.int/iris/bitstream/10665/183935/4/9789241549332_vol2_eng.pdf).
33. Convention on the Rights of Persons with Disabilities. In: United Nations Division for Social Policy and Development Disabilities CRPD [website]. (https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities.html).
34. WHO. Ensuring human rights in the provision of contraceptive information and services. Geneva; 2013. (http://apps.who.int/iris/bitstream/10665/102539/1/9789241506748_eng.pdf).
35. WHO. Adolescent job aid: a handy desk reference tool for primary level health workers. Geneva, Development. Geneva; 2010. (http://apps.who.int/iris/bitstream/10665/44387/1/9789241599962_eng.pdf).
36. WHO. Core competencies in adolescent health and development for primary care providers, including a tool to assess the adolescent health and development component in pre-service education. Geneva; 2015. (http://apps.who.int/iris/bitstream/10665/148354/1/9789241508315_eng.pdf?ua=1).
37. Nair M, Baltag V, Bose K, Boschi-Pinto C, Lambrechts T, Mathai M. Improving the quality of health care services for adolescents, globally: a standards-driven approach. J Adolesc Health. 2015 Sep:57(3):288-298. (https://www.ncbi.nlm.nih.gov/pmc/articles/pmc4540599/).
38. Bundy DAP, de Silva N, Horton S, Patton GC, Jamison DT, editors. Disease control priorities. Third edition. Volume 8: child and adolescent health and development. Washington DC: World Bank; 2017 (in press).
39. Langford R, Bonell C, Jones H, Pouliou T, Murphy S, Waters E et al. The WHO health promoting school framework for improving the health and well-being of students and their academic achievement. Cochrane Database Syst Rev. 2014(4):CD008958. (http://onlinelibrary.wiley.com/doi/10.1002/14651858.CD008958.pub2/pdf).
40. UNODC. International standards on drug use prevention. Vienna; 2015. (https://www.unodc.org/documents/prevention/unodc_2013_2015_international_standards_on_drug_use_prevention_e.pdf).
41. WHO. Preventing youth violence: an overview of the evidence. Geneva; 2015. (http://apps.who.int/iris/bitstream/10665/181008/1/9789241509251_eng.pdf?ua=1&ua=1&ua=1).
42. WHO. Preventing early pregnancy and poor reproductive outcomes among adolescents in developing countries: what the evidence says. Geneva; 2011. (http://apps.who.int/iris/bitstream/10665/70813/1/who_fwc_mca_12_02_eng.pdf).
43. UNESCO, UNODC, WHO. Education sector responses to the use of alcohol, tobacco and drugs: good policy and practice in health education. Paris; 2017. (http://unesdoc.unesco.org/images/0024/002475/247509e.pdf).
44. Duffy M, Lamstein S, Lutter C, Koniz-Booher P. Review of programmatic responses to adolescent and women's nutritional needs in low and middle income countries. Arlington: USAID and the Strengthening Partnerships, Results, and Innovations in Nutrition Globally (SPRING) project; 2015. (https://www.spring-nutrition.org/sites/default/files/publications/reports/spring_review_programmatic_responses.pdf).
45. WHO. Beginning with the end in mind: planning pilot projects and other programmatic research for successful scaling up. Geneva; 2011. (http://apps.who.int/iris/bitstream/10665/44708/1/9789241502320_eng.pdf).

46. EWEC. A global strategy for every woman every child in every setting. EWEC Technical Content Workstream Working Group on Humanitarian Challenges (21/03/2015). (http://www.everywomaneverychild.org/wp-content/uploads/2015/02/15__revised_EWEC_Humanitarian150322RKMT-HD_11__2015-03-24.pdf).
47. Women's Refugee Commission. We believe in youth. Global Refugee Youth Consultations final report, November 2016. New York; 2016. (https://www.womensrefugeecommission.org/youth/resources/document/download/1385)..
48. WHO. Guidance note on disability and emergency risk management for health. Geneva; 2013. (http://apps.who.int/iris/bitstream/10665/90369/1/9789241506243_eng.pdf).
49. WHO, UNICEF, USAID. Improving nutrition outcomes with better water, sanitation and hygiene: practical solutions for policies and programmes. Geneva; 2015. (https://www.unicef.org/media/files/IntegratingWASHandNut_WHO_UNICEF_USAID_Nov2015.pdf).
50. Inter-agency Working Group on Reproductive Health in Crises. Inter-agency field manual on reproductive health in humanitarian settings. 2010 revision for field review. (https://www.ncbi.nlm.nih.gov/books/NBK305149/pdf/Bookshelf_NBK305149.pdf).
51. WHO. Do's and don'ts in community-based psychosocial support for sexual violence survivors in conflict-affected settings. Geneva; 2012. (http://www.unhcr.org/protection/health/50b48c4f6/dos-donts-community-based-psychosocial-support-sexual-violence-survivors.html).
52. WHO. WHO ethical and safety recommendations for researching, documenting and monitoring sexual violence in emergencies. Geneva; 2007. (http://www.who.int/gender/documents/oms_ethics&safety10aug07.pdf).
53. WHO. Mental health and psychosocial support for conflict-related sexual violence: principles and interventions. Geneva; 2012. (https://www.unicef.org/protection/files/summary_en_.pdf).
54. Child Protection Working Group. Minimum standards for child protection in humanitarian action. Geneva; 2012. (https://www.unicef.org/iran/Minimum_standards_for_child_protection_in_humanitarian_action.pdf).
55. International Network for Education in Emergencies. INEE minimum standards for education: preparedness, response, recovery. New York; 2010. (http://toolkit.ineesite.org/toolkit/ineecms/uploads/1012/inee_guidebook_en_2012%20lores.pdf).
56. Save the Children. Delivering education for children in emergencies: a key building block for the future. London; 2008. (http://www.savethechildren.org/atf/cf/%7b9def2ebe-10ae-432c-9bd0-df91d2eba74a%7d/delivering_education_emergencies.pdf).
57. International Network for Education in Emergencies. Guidelines for child friendly spaces in emergencies. New York; 2011. (https://www.unicef.org/protection/child_friendly_spaces_guidelines_for_field_testing.pdf).
58. Inter-Agency Standing Committee. Guidelines for HIV/AIDS interventions in emergency settings. Geneva; 2003. (http://data.unaids.org/publications/external-documents/iasc_guidelines-emergency-settings_en.pdf).
59. WHO. Sexual and reproductive health during protracted crises and recovery. Geneva 2011. (http://apps.who.int/iris/bitstream/10665/70762/1/who_hac_bro_2011.2_eng.pdf).
60. WHO. Health programme evaluation: guiding principles for its application in the managerial process for national health development. Geneva; 1981. (http://www.who.int/iris/handle/10665/40674).
61. WHO. Monitoring, evaluation and review of national health strategies. A country-led platform for information and accountability. Geneva; 2011. (http://www.who.int/healthinfo/country_monitoring_evaluation/1085_IER_131011_web.pdf).
62. Hindin M, Christiansen C, Ferguson B. Setting research priorities for adolescent sexual and reproductive health in low-and middle-income countries. Bull World Health Organ. 2013;91(1):10-8. (https://www.ncbi.nlm.nih.gov/pmc/articles/pmc3537249/pdf/blt.12.107565.pdf).
63. Nagata J, Ferguson B, Ross D. Research priorities for eight areas of adolescent health in low-and middle-income countries. J Adolesc Health. 2016;59(1):50-60. (http://www.sciencedirect.com/science/article/pii/s1054139x16000951).


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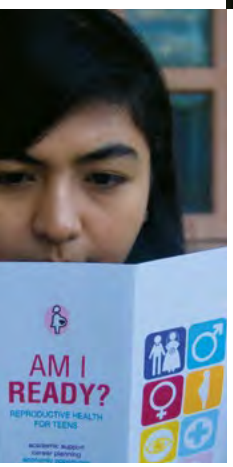


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