# Global Accelerated Action for the Health of Adolescents (AA-HA!): Implementation Guidance DRAFT

## KEY MESSAGES

World Health Organization, 15 December 2016

## Section 1. INTRODUCTION

1. Adolescents (aged 10-19 years) make up one-sixth of the world's population and are extremely diverse, but share key developmental experiences, such as rapid physical growth, hormonal changes, sexual development, new and complex emotions, and an increase in intellectual capacities.
2. Adolescent health is affected by positive physical, neurological, and psychosocial development, as well as a diverse array of possible burdens, including unintentional injury, interpersonal violence, sexual and reproductive health (SRH) concerns, communicable diseases, non-communicable diseases, and mental health issues.
3. In addition, numerous important risk factors for health problems start or are consolidated during adolescence and may continue over the life course, such as tobacco use, inadequate nutrition, physical inactivity, and alcohol and drug use.
4. There are strong demographic, public health, economic, and human rights reasons to invest in the health and the development of adolescents. For example, investing in adolescent health will benefit adolescents now, adolescents in their future lives, and also the next generation.
5. Three critical, overarching concepts in adolescent health programming are universal health coverage, quality of care, and positive development.
6. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) takes a life-course approach that aims for the highest attainable standards of health and wellbeing — physical, mental, and social — at every age. It identifies 27 evidence-based adolescent health interventions.
7. The Global Accelerated Action for the Health of Adolescents (AA-HA!) Implementation Guidance document has been developed to support the Global Strategy and to provide countries with a basis for developing a coherent national plan for the health of adolescents. Specifically:
    - *Section 2* reviews adolescent positive development and major disease burdens;
    - *Section 3* describes the 27 Global Strategy adolescent health interventions in detail;
    - *Section 4* outlines how a country can prioritize health interventions for its particular adolescent population;
    - *Section 5* describes important aspects of successful national adolescent health programming; and
    - *Section 6* reviews adolescent health monitoring, evaluation, and research guidelines and priorities.

## Section 2. ADOLESCENT HEALTH

1. Positive *physical* health in adolescence includes pubertal development, having adequate sleep, being injury-free, having a nutritious diet, being fit, and not having unwanted pregnancies, HIV, or other sexually-transmitted infections (STIs).
2. Positive *neurological* development in adolescence is facilitated by: constructive forms of risk-taking; learning and experiences to stimulate brain connections; opportunities to make decisions and develop values; and cultivation of social skills and concern for justice through group activities.
3. Positive *psychosocial* health in adolescence includes: a sense of identity and self-worth; sound family and peer relationships; an ability to learn and be productive; and a capacity to use cultural resources to maximize development.
4. There are great disparities in adolescent health globally. In 2012, over two-thirds of adolescent deaths occurred in African low- and middle-income countries (LMICs) (43%) and Southeast Asian LMICs (27%), two areas which have both large adolescent populations and high rates of adolescent mortality.
5. Some conditions are major adolescent burdens across most regions, including road injury, self-harm, lower respiratory infections, drowning, and unipolar depression. Some are major burdens for both sexes and age groups (10-14 and 15-19 year olds), including road injury, HIV/AIDS, and unipolar depression.
6. When data are analysed for their relative importance *within* (not between) groups, some adolescent burdens rank highly within specific regions:
    - *African LMICs:* HIV/AIDS, meningitis, and diarrheal diseases.
    - *American LMICs:* interpersonal violence and asthma.
    - *Eastern Mediterranean LMICs:* collective violence and legal intervention, and iron-deficiency anaemia.
    - *European LMICs:* stroke, anxiety disorders, and back and neck pain.
    - *Southeast Asian LMICs:* self-harm, diarrhoeal diseases, and iron-deficiency anaemia.
    - *Western Pacific LMICs:* leukaemia, congenital anomalies, back and neck pain, and alcohol use disorders.
    - *High-income countries:* interpersonal violence, alcohol use disorders, and back and neck pain.
7. Similarly, some adolescent burdens have a particularly high ranking among males (drowning, interpersonal violence) or females (maternal causes, anxiety disorders), or among younger adolescents (diarrheal diseases, iron-deficiency anaemia) and older adolescents (self-harm).
8. Key adolescent health concerns in humanitarian and fragile settings are: malnutrition; disability; unintentional injury; violence; SRH needs (including early pregnancy, HIV/AIDS and other STIs, and unsafe abortion); water, sanitation, and health needs (including menstrual hygiene management); and mental health.

## Section 3. EVIDENCE-BASED INTERVENTIONS

1. There is a tremendous evidence base of adolescent health interventions which address diverse conditions, including positive development, unintentional injuries, violence, sexual and reproductive health, communicable diseases, non-communicable diseases, mental health, and humanitarian and fragile settings.
2. The main drivers of adolescent health are largely outside of the health system, so many interventions involve other sectors. The education sector is a particularly important because of the opportunity it provides to positively influence adolescent health through intensive, long-term, and large-scale initiatives implemented by professionals.
3. Some of the most effective interventions to reduce major adolescent health burdens are universal to general populations and function at structural and environmental levels. Examples are transportation policies and legislation to reduce road injury; water and sanitation systems to prevent diarrheal diseases; and air quality policies to reduce lower respiratory infections.
4. Some adolescent-specific health interventions are universal to all adolescents. These often function at organizational, community, interpersonal, and individual levels. Examples are school-based puberty education to promote positive development; adolescent-friendly health services to prevent early and unintended pregnancies; parenting programmes to support adolescents with emotional, behavioural, or developmental disorders; and community initiatives to reduce the availability of alcohol and create alcohol-free environments for youth.
5. Other effective adolescent health interventions target at-risk adolescent sub-populations. Examples are HIV testing, counselling, and linkage to services for adolescent key populations; iron supplementation for menstruating adolescents where iron-deficiency anaemia is highly prevalent; community-based initiatives to end female genital mutilation; and clinical management and psychosocial support to survivors of sexual violence in humanitarian and fragile settings.

## Section 4. NATIONAL PRIORITIZATION

1. Historically, most adolescent health services have been subsumed under those for children or adults. By the 1980s, some countries began developing and implementing adolescent-specific national health programming, mainly due to growing awareness of adolescent SRH problems. In recent decades, it has become increasingly evident that other adolescent health concerns also warrant adolescent-specific national programming.
2. The nature, scale, and impact of adolescent health needs differ between countries, so it is important for each country to assess its own particular adolescent health situation and resources before determining which conditions and interventions to prioritize within national programming. Three key steps in that process are an adolescent health needs assessment, a programme and policy landscape analysis, and prioritization exercises.
3. *A needs assessment* takes stock of the adolescent health situation, considering the current status as well as trends and inequities in exposure to risk factors, health, and health service access. It helps identify which conditions have the greatest impact on quality of life and injury and disease burdens, both among adolescents in general and among those most at risk for health problems.
4. *A landscape analysis* reviews existing adolescent health programmes and policies as well as related legislation, country capacity, and resources. It should also include review of current global guidance on which interventions are the most evidence-based and effective to address the conditions identified in the needs assessment.
5. *Prioritization exercises* identify (a) the highest priority adolescent conditions for focused efforts; and (b) the most evidence-based and feasible interventions and delivery mechanisms to address them. This process takes into consideration the most vulnerable adolescents, the urgency and scale of particular burdens, the existence of effective and appropriate interventions to reduce them, and the availability of resources and capacity to implement or expand priority interventions equitably.
6. Over time, it is important for countries to reassess national adolescent health programming priorities in this way at intervals, in order to best meet changing adolescent health needs.

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## Section 5. NATIONAL PROGRAMMING

1. Promoting an adolescent health focus in all policies as part of the routine strategic and operational planning of the health and other relevant sectors should be a key priority. Adolescent-specific projects should not replace the obligation of sectors to systematically, continuously, and sustainably improve their response to the needs of adolescents.
2. The health sector should systematically participate in the strategic and operational planning of other sectors to ensure that an "Adolescent Health in All Policies (AHiAP)" approach is being practiced in policy formulation, implementation, monitoring, and evaluation. AHiAP could be facilitated by establishing a national adolescent health interest group that includes youth-serving and youth-led advocates as well as representatives from the highest level of the government.
3. To guarantee on-going, dedicated attention to adolescent health issues within the health sector, countries may consider mandating an adolescent health focal point in the Ministry of Health, with responsibilities for championing adolescent health within the ministry, coordinating an adolescent health focus in all health programmes, and serving as a liaison person for intersectoral action.
4. In many countries, health systems may not be mature enough to routinely adopt an adolescent health focus in their work, so consideration may need to be given to establishing a national adolescent health programme, with a broad scope across health priorities. In such a case, the adolescent health focal point in the Ministry of Health will also be the coordinator of the national adolescent health programme.
5. Investing in school health is a fundamental priority for intersectoral programmes. Countries that do not have school health programmes may consider establishing them, and countries that do have school health programmes should continuously improve them to align them with existing evidence of effectiveness and emerging priorities.
6. Ensuring healthy lives and promoting wellbeing for all at all ages (SDG no. 3), universal health coverage, and leaving no one behind should be key considerations in programming for adolescent health. An equity lens should inform planning at all stages of programming, from identifying goals, targets, objectives and vulnerable populations, through to defining indicators to monitor achievements and plan interventions, services, and activities.

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## Section 6. MONITORING, EVALUATION, AND RESEARCH

1. Through a consultative process, the Global Strategy for Women's, Children's and Adolescents' Health has arrived at a list of 16 core indicators. These include several that are either adolescent-specific or include adolescents, such as the adolescent mortality and birth rates, proficiency in reading and mathematics, and experience of sexual violence.
2. Beyond the Global Strategy indicators, which largely focus on outcomes and health impact, adolescent health programmes will also need to monitor inputs, processes and outputs.
3. Two recent global adolescent health-related research prioritization exercises which have been coordinated by WHO form a useful basis for the focus of research in adolescent health over the next few years.