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

--- ANNEX 1 ONLY ---

World Health Organization, 13 December 2016

ANNEX 1. ADDITIONAL INFORMATION ABOUT THE GLOBAL AA-HA! IMPLEMENTATION GUIDANCE DOCUMENT

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A1.1. THE GLOBAL STRATEGY FOR WOMEN'S, CHILDREN'S AND ADOLESCENTS' HEALTH (2016-2030)

On January 1st, 2016, spearheaded by the United Nations, the seventeen Sustainable Development Goals (SDGs) of the 2030 Agenda for Sustainable Development officially came into force. Over the next fifteen years, these goals will guide countries as they mobilize efforts to end all forms of poverty, fight inequalities, and tackle climate change. The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) is aligned to the SDGs, as seen in its "survive, thrive, and transform" objectives and targets, i.e. end preventable deaths, ensure health and wellbeing, and expand enabling environments (EWEC 2015). The Global Strategy provides a roadmap for ending all preventable maternal, newborn, child, and adolescent deaths by 2030, and for improving their overall health and wellbeing. It is universal and applies to all people (including the marginalized and hard-to-reach), in all places (including crisis situations), and to transnational issues. For the first time, building on the previous strategy that specifically targeted women and children, adolescents are at the heart of the Global Strategy. This acknowledges not only the unique health challenges facing adolescents, but also their pivotal role alongside women and children as key drivers of change in the new sustainable development era.

The Global Strategy takes a life-course approach that aims for the highest attainable standards of health and wellbeing — physical, mental and social — at every age. A person's health at each stage of life affects health at other stages and also has cumulative effects for the next generation. The Global Strategy also guides greater integration among actors in the health sector and across other sectors, such as nutrition, education, water, hygiene and sanitation, and infrastructure. An Operational Framework has been developed to accompany the Global Strategy for its first five years, to be updated every five years through 2030 (EWEC 2016a). The Operational Framework will guide countries as they develop and refine their plans for women's, children's, and adolescents' health, based on country-identified needs and priorities. In addition, the Global Strategy Indicator and Monitoring Framework will support national SDG and health monitoring (EWEC 2016b). These global documents will guide national governments in the coming years as they develop and update reproductive, maternal, newborn, child, and adolescent health plans.

The Global Strategy is guided by several well-established principles of global health and sustainable development. It is country-led, universal, sustainable, rights-based, equity-driven, gender-responsive, evidence-informed, partnership-driven, people-centred, community-owned, and accountable to women, children, and adolescents. The Global Strategy identifies nine "Action Areas" to update national policies, strategies, plans and budgets, namely: country leadership, financing for health, health system resilience, individual potential, community engagement, multi-sectoral action, humanitarian and fragile settings, research and innovation, and accountability (Appendix I) (EWEC 2015). For each Action Area, the Global Strategy outlines three broad actions, and seven to thirteen specific interventions. The Operational Framework also identifies an "Ingredient for Action" for each of the nine Global Strategy Action Areas. For each Ingredient for Action, the Operational Framework lists up to five implementation objectives (Appendix I) (EWEC 2016a).

The Global Strategy lists many evidence-based interventions separately for women, children, and adolescents. As an age group, however, adolescents (10-19 years) overlap with both children (0-17 years) and women (18-19 years), and indeed many of the interventions identified specifically for children or women in the Global Strategy also address major adolescent injury and disease burdens. For example, maternal health interventions categorized in the list for women are equally relevant to pregnant adolescent girls, and numerous interventions categorized in the list for children address major adolescent health concerns (e.g. comprehensive care of adolescents infected with HIV; or prevention and management of malaria, meningitis, and diarrhoea).

Appendix II compiles the 26 Global Strategy interventions for children and adolescents which are directly relevant to adolescent health, and adds one composite intervention that represents the 48 maternal health interventions. Appendix III summarizes broader Global Strategy health system and multi-sectoral policies and interventions which are relevant to adolescent health, including those related to emergency preparedness. The Global Strategy stresses that the Sustainable Development Goals will not be reached without specific attention to humanitarian and fragile settings that face social, economic, and environmental shocks and disasters (e.g. armed conflict, natural disaster, epidemic, or famine), as these can result in a critical threat to the health, safety, security or well-being of large groups of people. The Global Strategy further notes that humanitarian emergency responses have historically given insufficient attention to protecting adolescents, who in crises may face increased risks of poor physical and mental health outcomes, harassment, assault, and rape.

In addition, a fundamental principle of the Global Strategy and this guidance document is that adolescents should be involved as actors and partners in the planning, implementation, monitoring, and evaluation of interventions to improve and maintain their health and development. This is discussed more in Box A1.1.

Box A1.1. Involvement of adolescents as partners in health programming.

Adolescents can be a force for their own health and for the health of their families and communities. They also have the right to participate in decisions that affect their lives. Adolescents around the world already contribute in many ways to their families and communities, for example, by taking responsibility for domestic chores and caring for older and younger family members. This engagement gives them both a stake in their communities and important first-hand perspectives on a range of life issues. Increasingly, young people are developing local, national, regional, and international networks, and their voices are reaching influential platforms, earning respect and appreciation (e.g. Global Youth Meet on Health 2015). Adolescents are increasingly a strong transformative force, with great potential creativity, maturity, and roles as change agents. In taking a more active role in the development, implementation, and monitoring of health interventions that affect them, they not only realize their potential but contribute to improved programming and outcomes.

Many stakeholders agree that adolescents can and should have a say in the programmes and policies that affect their lives, but ensuring their meaningful involvement is not always straightforward. Several global resources have been developed to provide practical guidance on facilitating youth engagement in multi-sectoral development and health programming (e.g. ECPAT International 2007; FHI et al. 2008; SPW/DFID Youth Working Group 2010; USAID 2014; WHO and UNAIDS 2015a). For example, the 2015 WHO and UNAIDS "Global Standards for Quality Health-Care Services for Adolescents" identifies adolescent participation as one of the eight global standards of adolescent health care, specifically: "Adolescents are involved in the planning, monitoring and evaluation of health services and in decisions regarding their own care, as well as in certain appropriate aspects of service provision." That guidance document stresses that adolescents have important contributions to make in health-care policy-making, planning, implementation, and monitoring. If empowered and trained, adolescents also can be effective peer educators, counsellors, trainers, and advocates, particularly as they usually have the best knowledge about their own lives and needs, and they have the capacity to identify best approaches or solutions to health challenges.

At an individual level, ignoring adolescent views regarding their own health care can lead to disengagement (e.g. discontinuation of a treatment) and loss to follow-up. At a broader level, upholding adolescents' participation in their own care and that of their community supports the provision of sustainable, acceptable, locally appropriate, and more effective solutions, which ensures that more adolescents will seek and remain engaged in care. Towards that end, Table 1.1 lists measureable criteria for adolescent participation in health care (WHO and UNAIDS 2015a).

Table 1.1. Measurable criteria for adolescent participation in health care services.

Input	Process	Output
1. The governance structure of the facility includes adolescents. 2. There is a policy in place to engage adolescents in service planning, monitoring, and evaluation. 3. Health care providers are aware of laws and regulations that govern informed consent, and the	4. The health facility carries out regular activities to identify adolescents expectations about the service, and to assess their experience of care, and it involves adolescents in the planning, monitoring, and evaluation of health services. 5. Health care providers provide accurate and clear information on the medical condition and management/treatment options, and explicitly take into account the	7. Adolescents are involved in planning, monitoring, and evaluation of health services. 8. Adolescents are involved in decisions regarding their own care. 9. Adolescents are involved in certain aspects of health service provision.

Input	Process	Output
consent process is clearly defined by facility policies and procedures in line with laws and regulations.	adolescent's decision on the preferred option and follow-up actions. 6. The health facility carries out activities to build adolescents' capacity in certain aspects of health service provision.	

Source: WHO and UNAIDS and 2015a.

A1.2. GLOBAL AA-HA! IMPLEMENTATION GUIDANCE DEVELOPMENT

The Sixty-eighth World Health Assembly endorsed a proposal by the WHO Secretariat to develop an adolescent health framework aligned with the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) and its Operational Framework. The goal of this Global AA-HA! Implementation Guidance document is to provide countries with a basis for developing a coherent national plan for the health of adolescents. It will help align the contributions of relevant stakeholders in planning, implementing, and monitoring actions across sectors towards agreed goals to help adolescents to survive, thrive, and transform the environment in which they live. The primary target audience for this document is national-level policy makers and programme managers. Secondary audiences include representatives of non-governmental organizations and funding agencies, researchers, educators, activists, and community and religious leaders.

A document such as this one, which addresses the health intervention and programming needs of approximately one-fifth of the world's population, cannot be exhaustive in its review of relevant information. Instead, each section will provide an overview of relevant issues and evidence-based examples, with reference to key global or regional sources where readers can obtain more detailed information for specific topics of interest.

A1.2.1. GLOBAL CONSULTATION ON THE PROPOSED PRINCIPLES OF THE GLOBAL AA-HA! IMPLEMENTATION GUIDANCE DOCUMENT

The first round of global consultation on the development of the Global AA-HA! Implementation Guidance document took place between October 2015 and March 2016 in order to review the proposed principles for the document. In total, 888 participants from 126 countries in all six WHO regions participated in face-to-face or online surveys (WHO 2016d). Participants represented individual adolescents and young adults, youth groups, and government, civil society, private sector, academic, and donor agencies. Among respondents who indicated their country of origin (n=599), the largest number were from the Americas (34%), followed by the African (22%), Southeast Asian (17%), European (17%), Western Pacific (7%) and Eastern Mediterranean (3%) regions. Adolescents and young adults from 57 countries participated and made up 12% of the total number of respondents. Public health or national/regional health managers from 72 countries also participated.

Overall, this consultation found there was strong agreement with all principles proposed for the Global AA-HA! Implementation Guidance document, i.e. the central involvement of youth; equity, human rights, and gender equality; a comprehensive approach to positive adolescent development; reinforcement of relevant existing WHO global and regional strategies and action plans; acknowledgement of diversity and adequate attention to vulnerable adolescents; promotion of integrated responses that address multiple outcomes, risk factors, and determinants; and flexibility to account for various epidemiological and socio-economic contexts. Sixty percent of respondents

agreed or strongly agreed that the document should have the role of the health sector as its primary focus. However, there also was overwhelming agreement that it should address social determinants of health, the role of sectors other than health, and performance targets and indicators to ensure accountability. There were no major differences between answers given by young people and other groups.

During this first round of consultation, participants were invited to suggest the one most important thing that Global AA-HA! document should aim to achieve. The most frequent suggestions were:

- give attention to and involve adolescents; and
- address a range of health needs related to comprehensive prevention and care (e.g. mental health, violence, nutrition, and sexual and reproductive health).

Conversely, when participants were invited to suggest the single most important thing that the Global AA-HA! document should avoid, the most frequent recommendations were to avoid:

- not involving youth properly;
- creating a general blueprint rather than accounting for specific contexts; and
- not being comprehensive enough (i.e. focusing too much on a single issue).

A1.2.2. ASSESSING ADOLESCENT HEALTH BASED ON THE GLOBAL HEALTH ESTIMATES

The main source of information on adolescent health in the Global AA-HA! Implementation Guidance document is the 2012 Global Health Estimates (GHE) database. The GHE database compiles health statistics reported by countries to WHO on an annual basis; it provides comprehensive and comparable estimates of rates of mortality and disability-adjusted life years (DALYs) lost. The DALY measure combines an individual's estimated years of life lost through premature death and estimated years of life lived in states of less than optimal health (WHO 2013b). The sum of DALYs across a population is a way to measure the gap between current health status and an ideal health situation in which the entire population lives to an advanced age, free of disease and disability.

The Global AA-HA! document draws on the 2012 GHE five leading causes of adolescent mortality and DALYs lost; these data are described in Section 2 and also are accessible online, within the WHO Global Health Observatory app: http://apps.who.int/gho/data/view.wrapper.MortAdov?lang=en&menu=hide. The 2012 GHE database only provides the leading five causes of adolescent mortality and DALYs lost, because there is considerable uncertainty about empirical estimates of mortality rates and DALYs lost for lower-ranked causes. In this document, top ranked global data are reported along with those for seven "modified WHO Regions", in which all the high-income countries have been extracted from each of the six WHO Regions into a separate group of high-income countries (HICs), with the remaining low- and middle-income countries (LMICs) grouped together for each of the six WHO Regions Appendix IV).

The GHE database offers important insights into adolescent health globally and disaggregated by WHO Region, country income level, sex, and age group. Nonetheless, assessment of rates of mortality or DALYs lost only give a partial view of the relative importance of health conditions. For example, it may not capture key aspects of positive adolescent health and development (e.g. menstrual hygiene; access to contraception). It also may underestimate the importance of disease burdens which are highly sensitive and challenging to measure (e.g. female genital mutilation, induced abortion, sexually transmitted infections, sexual violence, and self-harm). Also, some

burdens may result from diverse causes and outcomes, so they are difficult to define and assess consistently (e.g. maternal conditions, skin diseases). Finally, some countries with very limited health systems may underreport conditions due to poor diagnostic services, health care access, or documentation (e.g. road injury, diseases related to poor water and sanitation). To compensate for such limitations, the Global AA-HA! document also draws on complementary research sources, methods, and measures, including qualitative methods and quantitative surveys.

A1.2.3. REVIEW AND SELECTION OF EVIDENCE-BASED INTERVENTIONS FOR THE GLOBAL AA-HA! IMPLEMENTATION GUIDANCE

Several thousand global guidance documents related to adolescent health interventions have been published in the last decade by WHO, other UN partners, and other stakeholders, and it would not have been feasible to review and include all of them in this Global AA-HA! Implementation Guidance document. Instead, an initial search and review was conducted of more than 800 relevant, recent publications from all WHO departments. This review provided the vast majority of the intervention examples described in Section 3. When there were gaps in the WHO literature, however, other UN publications related to the topic of interest were searched and reviewed. When those sources also proved insufficient, a third tier of search and review took place focused on other major international agency publications and/or review articles in academic journals.

The intervention examples described in Section 3 were chosen to represent diverse approaches, multiple sectors, and varying levels of the ecological model. They also target different kinds of populations. Some interventions, such as those which strengthen road safety legislation and enforcement, take place at a broad, societal level but have major implications for adolescent risk factors or disease burden. Some, such as systematically improved WASH facilities in secondary schools, focus on adolescents in general. Other interventions, such as those which promote voluntary medical male circumcision or which seek to end female genital mutilation (FGM), specifically target adolescent sub-populations with high disease burdens (i.e. uncircumcised boys in areas with high HIV prevalence, or girls at risk of FGM in communities which practice it).

There are many hundreds of interventions which are potentially relevant to adolescent health and which are documented in WHO guiding documents over the last decade, so Section 3 provides illustrative examples rather than an exhaustive overview. Sources are referenced for readers who would like more in-depth guidance on particular topics, so national government representatives can draw on the online materials cited here to develop detailed adolescent health programmes tailored to their particular populations. To better illustrate the range of possible resources and approaches which national governments could employ, interventions are described in some depth for one major adolescent disease burden within each of the six broad health categories, specifically: road injury; youth violence; HIV; water, sanitation, and hygiene (WASH)-related conditions; ischaemic heart disease and cerebrovascular disease; and self-harm.

A1.2.4. ADOLESCENT PARTICIPATION

As already noted, adolescents and young people were consulted about the development of this Global AA-HA! Implementation Guidance Document in a series of meetings in each of the WHO Regions, as well as through two global, online surveys. In addition, two special studies were commissioned to enhance the participation and input of adolescents in Global AA-HA! development and finalization. First, a series of focus group workshops were conducted with young and/or vulnerable in the six WHO Regions. In each location, workshops were held with 1-2 groups of early adolescents (generally 12-14 years old) as well as 1-2 groups of vulnerable adolescents, i.e. those who were new immigrants or out-of-school (Hong Kong and Slovenia); LGBT (Indonesia and

Philippines); pregnant and/or rural (Nigeria and Turkey); refugee and/or rural (occupied Palestinian territories); or from urban settlements (Columbia). In the workshops, adolescents were asked about their perceptions of health and happiness, their main concerns about those issues, the types of actions they believe can be implemented in the schools and communities to improve them, and the most important thing that adolescents themselves can do to improve their health and happiness, both now and the in the future.

The second study involved secondary data analysis of health themes in the Global Early Adolescent Study, which used narrative interviews with 10-14 year olds to examine the development of gender norms that predispose sexual health risks and contribute to healthy sexuality. For the Global AA-HA! document, young adolescent perceptions of the following topics were examined: what is healthy and unhealthy; empowerment and related factors; what influences health and ill-health; risk and protective factors including safety and security; actions they can take to stay healthy; and access to and use of media including social media. Themes were analysed from study sites in Belgium, China, Congo, Ecuador, Egypt, India, Kenya, Nigeria, Scotland, and the United States of America.

All of the adolescent opinions and feedback above informed the on-going analysis, interpretation, and writing of this Global AA-HA! Implementation Guidance document. To illuminate key concepts, adolescent quotes from the two commissioned studies are also highlighted throughout the document in offset orange boxes.

A1.2.5. LIST OF COUNTRY CASE STUDIES

In total, 64 country case studies are provided across Sections 3-6 of the Global AA-HA! Implementation Guidance document and their accompanying Annexes to illustrate key actions for adolescent health at different levels of the ecological model, and how individual countries have achieved them. The full list is provided below:

Section 3:

CASE STUDY 1. India's national menstrual hygiene management programme for rural adolescent girls.
CASE STUDY 2. Thailand's driving education and training programmes for young novice motorcycle drivers.
CASE STUDY 3. Brazil's programme to reduce alcohol-related violence among high-risk youth.
CASE STUDY 4. Nicaragua's voucher program to increase access to sexual and reproductive health care among underserved adolescents.
CASE STUDY 5. Mozambique's peer support groups to promote treatment adherence among adolescents living with HIV.
CASE STUDY 6. Bangladesh's community initiatives to stop open defecation.
CASE STUDY 7. The Republic of Korea's comprehensive approach to promoting healthy diets through schools.
CASE STUDY 8. Iran's school mental health promotion project.
CASE STUDY 9. The occupied Palestinian territory's youth peer-to-peer counselling during a protracted crisis.

Section 4:

CASE STUDY 10. Zambia's adolescent health situation analysis and strategic plan.

Section 5:

CASE STUDY 11. England's teenage pregnancy strategy.
CASE STUDY 12. Kosovo's youth councils in refugee camps.

CASE STUDY A4.3. Mongolia's adolescent health situation analysis and prioritization of adolescent health conditions.

Annex 5:

CASE STUDY A5.1. Turkey's multi-sectoral action on drug dependence.
CASE STUDY A5.2. Argentina's municipal budgeting for youth participation.
CASE STUDY A5.3. Sierra Leone's involvement of children in the Truth and Reconciliation Commission.
CASE STUDY A5.4. The USA's expansion of minors' access to STI services.
CASE STUDY A5.5. South Africa's national policy on informed consent for testing children for HIV.
CASE STUDY A5.6. Malawi's cash transfer schemes as a vehicle to achieve public health objectives.
CASE STUDY A5.7. Australia's HPV vaccination programme.
CASE STUDY A5.8. Nepal's transitions from projects to a national adolescent sexual and reproductive health programme.
CASE STUDY A5.9. Chile's national programme for integrated adolescent and youth health.
CASE STUDY A5.10. Mozambique's multisectoral adolescent sexual and reproductive health programme.
CASE STUDY A5.11. The USA's school health services program.
CASE STUDY A5.12. Portugal's healthy schools programme.
CASE STUDY A5.13. South Africa's participatory, same-sex health education programme.
CASE STUDY A5.14. El Salvador's intersectoral experience in the empowerment of adolescent girls.
CASE STUDY A5.15. Australia's government funding of positive development approaches in programming.

Annex 6:

CASE STUDY A6.1. Lithuania's use of routine data to monitor the effect of a "Year of Sobriety".
CASE STUDY A6.2. England's monitoring and evaluation of its national teenage pregnancy strategy.
CASE STUDY A6.3. India's evaluation of an adolescent sexual and reproductive health services project.

A1.3. GLOSSARY OF KEY TERMS

Adolescent: A person aged 10 to 19 years. Table 1.2 shows how the term "adolescent" relates to the terms "child", "youth, "young adult", and "young person".

Table A1.2. Ages covered by terms "child", "adolescent", "youth", "young adult", and "young person".

Type of young person	Age in years															
	0-9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24
Child	√	√	√	√	√	√	√	√	√							
Adolescent		√	√	√	√	√	√	√	√	√	√					
Youth							√	√	√	√	√	√	√	√	√	√
Young Adult										√	√	√	√	√	√	√
Young Person		√	√	√	√	√	√	√	√	√	√	√	√	√	√	√

Source: United Nations Youth. 2016. Definition of youth. Accessed at http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf.

Burden of disease: The impact of a health problem in a population, as measured by rates of mortality and disability-adjusted life years (DALYs). It is not limited to disease, but also includes other burdens, such as disability caused by injury.

Country income level: Low-income countries are those with a gross national income per capita of $1,045 or less in 2014. Lower middle-income countries are those with a gross national income per capita of $1,046–$4,125. Upper middle-income countries are those with a gross national income per capita of $4,126–$12,735. High-income countries are those with a gross national income per capita of $12,736 or more (World Bank 2016).

Disability-adjusted life year (DALY): A measure that combines estimated years of life lost through premature death and the estimated years of life lived in states of less than optimal health (WHO 2013b). The sum of DALYs across a population is a way to measure the gap between current health status and an ideal health situation in which the entire population lives to an advanced age, free of disease and disability.

Demographic dividend: Accelerated economic growth that may result from a decline in a country's mortality and fertility rates, and a subsequent change in the age structure of the population. With fewer births each year, a country's young dependent population grows smaller in relation to the working-age population. With fewer people to support, a country has a window of opportunity for rapid economic growth (Population Reference Bureau 2012).

Demographic transition: A shift in population structure, for example, population change that occurs as a country transitions from high birth and death rates to lower birth and death rates, and from a pre-industrial to an industrialized economic system (Population Reference Bureau 2012).

Determinant: A factor that can affect the health of adolescents and their communities, including personal, social, economic, and environmental factors. Determinants occur at different ecological levels, e.g. individual characteristics (e.g. age, beliefs, income and social status, education, social support networks, genetics, health services, and gender); the immediate environment (e.g. parents; teachers; peers); social values and norms (e.g. gender norms restricting girls' access to education; encouragement of boys to take health-related risks); policies and laws (e.g. related to tobacco and alcohol); macro-social factors (e.g. distribution of money and resources); and physical and biological environment (e.g. malaria prevalence; access to toilets while menstruating). Some determinants may be inter-related and clustered, and together affect adolescent development and ability to learn and acquire skills (WHO 2016a).

Emergency situation: A single or multiple country event with minimal (Grade 1) to substantial (Grade 3) public health consequences that WHO has identified as requiring a response. In the months immediately after an emergency situation is graded, it is considered "acute"; when it is likely to continue for more than six months, its grade may be removed and it will become categorized as "protracted" (WHO 2013c).

Epidemiological transition: An epidemiological shift, for example, from mortality due to acute infectious diseases, to death via chronic, non-infectious, degenerative diseases, occurring as a result of higher standards of living and the introduction of medical and public health practices in high-income nations (Harper and Armelagos 2010).

Equity: Equity is the absence of avoidable, unfair or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically or by other means of stratification. "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential (WHO 2016e).

Evidence-based intervention: Interventions which have been found to be effective through rigorous evaluation. The particular standards used to evaluate effectiveness vary depending on many factors, including the type of health condition, intervention, and available data. For example, a biomedical intervention may be considered to have strong evidence of effectiveness if multiple experimental trials have consistently demonstrated positive impact on desired outcomes (UNICEF 2013). However, such research is not always feasible, particularly in non-biomedical fields where there may be a long and complex causal pathway between the implementation of an intervention and any potential impact on population health (WHO 2016a). In such cases, other criteria may be used to identify interventions with the strongest evidence-base.

Gender analysis: Gender analysis examines the differences between girls and boys and men and women in risk and exposure, health seeking behaviour, access and use of services, experiences in health care settings, treatment options, and impact of ill-health (WHO 2011). It also considers the interaction between biological and sociocultural factors, and access to and control over resources in relation to health, and identifies appropriate responses to different needs.

Health system function: A key purpose and activity of health systems. WHO identifies four functions as critical for health systems to perform: service provision; generation of human and physical resources which make service delivery possible; raising and pooling the resources used to pay for health care; and stewardship, i.e. setting and enforcing the rules and providing strategic direction for all actors. These functions are performed in the pursuit of three goals: health, responsiveness, and fair financing (WHO 2016f)

Health system strengthening: The process of identifying and implementing changes in policy and practice in a country's health system, so that the country can respond better to health system challenges. Health system strengthening also can be defined as any array of initiatives and strategies that enhance the functioning of a health system and lead to better health through improvements in access, coverage, quality, or efficiency (WHO 2016f).

Humanitarian and fragile settings: Settings that face social, economic, and environmental shocks and disasters, including conflict and post-conflict situations, transnational crises, countries that have experienced one or more serious natural disasters, and situations of protracted socioeconomic and political instability. In such settings, health challenges are particularly acute among mobile populations, internally displaced communities, and those in refugee or temporary camps (EWEC 2015).

Programme: A coordinated and comprehensive set of planned, sequential health promotion, protection, and prevention strategies, activities, and services designed to achieve well-defined objectives and targets. Programmes can take place at different ecological levels, including organizational (e.g. an individual school programme) and structural (e.g. a national education programme). A national programme usually has national, sub-national, and local coordinators, and dedicated funding to support planned activities. Within the health sector, the term "national health programme" is often used to indicate components of a national health care system which administer specific services (e.g. a national HIV programme; a national school health services programme) (WHO 2016f).

Programming: As used in this document, "programming" generally refers to the stage of a sector's planning cycle at the national level, in which newly identified priorities are translated into operational plans. Programming is also the process of re-organizing existing financial, human, and managerial resources and services to achieve better outcomes for selected priorities. Programming may be part of strengthening the core business of a sector (e.g. improving the adolescent health

content in pre-service education and training), or it may take place within the context of an adolescent-specific programme (e.g. programming for multisectoral action on adolescent health) (WHO 2016f).

Protective factor: A factor that encourages and sustains positive behaviours, reduces the risk of negative health behaviours and outcomes, and diminishes the effect of, and supports recovery from, negative health outcomes. Examples of protective factors for adolescent health include caring and meaningful relationships, appropriate structure and boundaries, opportunities for participation and contribution, and encouragement of self-expression (WHO 2002).

Risk factor: An attribute, characteristic, or exposure that increases the likelihood of an individual suffering a negative health outcome immediately or in the future. Some conditions can be both a risk factor and a burden of disease. For example, iron-deficiency anaemia is a risk factor for death or disability from post-partum haemorrhage, but it also causes lassitude and weakness (WHO 2016g).

A1.4. REFERENCES [Section 1 and Annex 1 combined]

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Appendix I. The Global Strategy for Women's, Children's and Adolescents' Health Action Areas, and its Operational Framework's Ingredients for Action and Implementation Objectives.
Sources: EWEC 2015 and EWEC 2016a.

ACTION AREA 1. COUNTRY LEADERSHIP: Reinforce leadership and management links and capacities at all levels; promote collective action.
Ingredient for Action 1. Country Leadership.
Implementation Objectives:

1. A strong multi-stakeholder country platform for women's, children's and adolescents' health
2. National and subnational SDG targets
3. A single prioritized, costed, national plan for women's, children's and adolescents' health
4. Effective stewardship and monitoring of implementation across sectors

ACTION AREA 2. FINANCING FOR HEALTH: Mobilize resources; ensure value for money; adopt integrative and innovative approaches.
Ingredient for Action 2. Aligning and Mobilizing Financing.
Implementation Objectives:

1. Identification of funding requirements and mobilization of all potential sources and support for funding
2. Coordination of funding flows
3. Strengthened financing capacity at decentralized level

ACTION AREA 3. HEALTH SYSTEM RESILIENCE: Provide good-quality care in all settings; prepare for emergencies; ensure universal health coverage.
Ingredient for Action 5. Strengthening Health Systems.
Implementation Objectives:

1. A strong health workforce
2. Reliable supply, access and availability of commodities
3. Effective health management information systems
4. Quality health services delivered at scale with resilience

ACTION AREA 4. INDIVIDUAL POTENTIAL: Invest in individuals' development, support people as agents of change; address barriers with legal frameworks.
Ingredient for Action 7. Establishing Priorities for Realizing Individual Potential.
Implementation Objectives:

1. An evidence and planning base for programming
2. Participation of adolescents
3. Priorities for adolescent programming
4. Priorities for early childhood development programming

ACTION AREA 5. COMMUNITY ENGAGEMENT: Promote enabling laws, policies and norms; strengthen community action; ensure inclusive participation.
Ingredient for Action 3. Supporting Community Engagement, Participation and Advocacy.
Implementation Objectives:

1. A supportive environment for community engagement, participation and social accountability
2. Strong advocacy and communication platforms
3. Integration of service delivery by communities into national systems

ACTION AREA 6. MULTISECTOR ACTION: Adopt a multisector approach; facilitate cross-sector collaboration; monitor impact.
Ingredient for Action 6. Enhancing Mechanisms for Multisectoral Action.
Implementation Objectives:

1. Governance to enable multisectoral action
2. Structures to support multisectoral collaboration

ACTION AREA 7. HUMANITARIAN AND FRAGILE SETTINGS: Assess risks, human rights, and gender needs; integrate emergency response; address gaps in the transition to sustainable development.
Ingredient for Action 8. Strengthening Capacity for Action in Humanitarian and Fragile Settings.
Implementation Objectives:

1. Humanitarian and fragile settings as core business of national health and social systems
2. A core emphasis on neonatal survival and sexual and reproductive health in humanitarian and fragile settings
3. Emphasis on human rights

ACTION AREA 8. RESEARCH AND INNOVATION: Invest in a range of research and build country capacity; link evidence to policy and practice; test and scale up innovations.
Ingredient for Action 9. Fostering Research and Innovation.
Implementation Objectives:

1. Strengthened implementation research capacity
2. An effective global innovation marketplace

ACTION AREA 9. ACCOUNTABILITY: Harmonize monitoring and reporting; improve civil registration and vital statistics; promote independent review and multi-stakeholder engagement.
Ingredient for Action 4. Reinforcing Global, Regional and National Accountability Mechanisms.
Implementation Objectives:

1. Robust accountability processes
2. Effective civil registration and vital statistics systems

Appendix II. The Global Strategy's essential, evidence-based interventions for adolescent health.
Source: EWEC 2015.
This list summarizes essential, evidence-based adolescent health policies and interventions, as identified in the Global Strategy for Women's, Children's, and Adolescents' Health.

UNINTENTIONAL INJURY

1. Prevention of injuries.
2. Assessment and management of adolescents who present with unintentional injury, including alcohol-related injury.

VIOLENCE

3. Prevention of violence.
4. Prevention and response to child maltreatment.
5. Prevention of and response to sexual and other forms of gender-based violence.

SEXUAL AND REPRODUCTIVE HEALTH, INCLUDING HIV

6. Comprehensive sexuality education.
7. Information, counselling and services for comprehensive sexual and reproductive health including contraception.
8. Prevention of and response to harmful practices, such as female genital mutilation and early and forced marriage.
9. Pre-pregnancy, pregnancy, birth, post-pregnancy, abortion (where legal), and post-abortion care [all 48 evidence-based interventions], as relevant to adolescents.
10. Prevention, detection and treatment of sexually transmitted and reproductive tract infections, including HIV and syphilis.
11. Voluntary medical male circumcision in countries with generalized HIV epidemics.
12. Comprehensive care of children infected with, or exposed to, HIV.

COMMUNICABLE DISEASES

13. Prevention, detection and treatment of communicable diseases, including Tuberculosis.
14. Routine vaccinations, e.g. human papillomavirus, hepatitis B, diphtheria-tetanus, rubella, measles.
15. Prevention and management of childhood illnesses, including malaria, pneumonia, meningitis and diarrhoea.
16. Case management of meningitis.

NON-COMMUNICABLE DISEASES, NUTRITION, AND PHYSICAL ACTIVITY

17. Promotion of healthy behaviour (e.g. nutrition, physical activity, no tobacco, alcohol or drugs).
18. Prevention, detection and treatment of non-communicable diseases.
19. Prevention, detection and management of anaemia, especially for adolescent girls. Iron supplementation where appropriate.
20. Treatment and rehabilitation of children with congenital abnormalities and disabilities.

MENTAL HEALTH, SUBSTANCE ABUSE, AND SELF-HARM

21. Care for children with developmental delays.
22. Responsive caregiving and stimulation.
23. Psychosocial support and related services for adolescent mental health and well-being.
24. Parent skill training, as appropriate, for managing behavioural disorders in adolescents.
25. Prevention of substance abuse.
26. Detection and management of hazardous and harmful substance use.
27. Prevention of suicide and management of self-harm / suicide risks.

Appendix III. The Global Strategy's broader interventions which are important to adolescent health.

Source: EWEC 2015.

This list summarizes additional, essential, evidence-based policies and interventions relevant which should be included within national strategies for adolescent health and relate to multiple sectors, as identified in the Global Strategy for Women's, Children's, and Adolescents' Health.

A. SPECIAL NEEDS IN HUMANITARIAN AND FRAGILE SETTINGS

1. In the event of humanitarian emergency, ensure deployment of essential health interventions, such as sexual and gender-based violence prevention, contraceptives (short-acting and long-acting emergency contraceptives), post-exposure prophylaxis.
2. In the event of humanitarian emergency, ensure that policies and practices promote, protect and support breastfeeding and other essential interventions for women's, children's and adolescents' health, based on context and need.

B. BROADER HEALTH SYSTEMS

Health systems policies and interventions [all 58 essential recommendations], as relevant to adolescents. These fall under ten broad categories:

1. Constitutional and legal entitlements; human rights-, equity-, and gender-based approaches: E.g. Universal access to health care and services, including sexual and reproductive health information, services, goods, and rights.
2. Strategies and plans: E.g. Prioritized and well-defined health targets and indicators for adolescents.
3. Financing: E.g. Sustainable financing of adolescents' health with effective and efficient use of domestic and external resources.
4. Human resources: E.g. Adequate recruitment, training, deployment and retention of health personnel.
5. Essential health infrastructure: E.g. Functional health facilities well-equipped to deliver anticipated services.
6. Essential medicines and commodities: E.g. Quality assurance and measures to maintain supplies at required levels.
7. Service equity, accessibility and quality: E.g. Adolescents' health services defined by level of health service delivery (primary, secondary, tertiary).
8. Community capacity and engagement: E.g. Community engagement in learning programmes to increase health literacy and care-seeking behaviours.
9. Accountability: E.g. Annual independent national and subnational adolescents' health / health sector review.
10. Emergency leadership and governance; health workforce; medical products, vaccines, and technology; health information; health financing; and service delivery: E.g. Emergency medical services system and mass casualty management.

C. MULTISECTORAL INTERVENTIONS

FINANCE AND SOCIAL PROTECTION

1. Reduce poverty, including through the use of gender- and child-sensitive cash transfer programmes designed to improve health.
2. Implement social protection and assistance measures ensuring access for adolescents.
3. Strengthen access to health insurance to decrease the impact of catastrophic out-of-pocket health spending, and to insurance related to other essential services and goods.

EDUCATION

4. Enable girls and boys to complete quality primary and secondary education, including by removing barriers that suppress demand for education.
5. Ensure access to education in humanitarian settings and in marginalized and hard-to-reach areas, including for individuals with disabilities.

GENDER

6. Promote women's social, economic and political participation.
7. Enforce legislation to prevent violence against women and girls and ensure an appropriate response when it occurs.
8. Promote gender equality in decision-making in households, workplaces and communities and at national level.
9. Prevent discrimination against women in communities, education, political, economic and public life.

PROTECTION: REGISTRATION, LAW AND JUSTICE

10. Strengthen systems to register every birth, death and cause of death and to conduct death audits.
11. Provide protection services for adolescents that are age- and gender-appropriate.
12. Establish and enact a legal framework for protection, ensuring universal access to legal services (including to register human rights violations and have recourse to remedial action against them).

WATER AND SANITATION

13. Provide universal access to safely managed, affordable and sustainable drinking water.
14. Invest in education on the importance of safely managed water use and infrastructure in households, communities, schools and health facilities.
15. Provide universal access to improved sanitation facilities and hygiene measures and end open defecation.
16. Encourage implementation of sanitation safety plans.

AGRICULTURE AND NUTRITION

17. Enhance food security, especially in communities with a high poverty and mortality burden.
18. Protect, promote and support optimal nutrition, including legislation on marketing of breast milk substitutes and of foods high in saturated fats, trans-fatty acids, sugars, or salt.

ENVIRONMENT AND ENERGY

19. Reduce household and ambient air pollution through the increased use of clean energy fuels and technologies in the home (for cooking, heating, lighting).
20. Take steps to mitigate and adapt to climate changes that affect the health of adolescents.
21. Eliminate non-essential uses of lead (e.g. in paint) and mercury (e.g. in health care and artisanal mining) and ensure the safe recycling of lead- or mercury-containing waste.
22. Reduce air pollution and climate emissions and improve green spaces by using low-emissions technology and renewable energy.

LABOUR AND TRADE

23. Expand opportunities for productive employment.
24. Ensure gender equality.
25. Enforce decent working conditions.
26. Provide entitlements for parental leave and for childcare for working parents, and promote incentives for flexible work arrangements for men and women.
27. Detect and systematically eliminate child labour.
28. Create a positive environment for business and trade with regulations to protect and promote the health and well-being of individuals and populations.

INFRASTRUCTURE, INFORMATION AND COMMUNICATION TECHNOLOGIES AND TRANSPORT

29. Build health-enabling urban environments for adolescents, through improved access to green spaces and walking and cycling networks that offer dedicated transit, safe mobility and physical activity.
30. Develop healthy, energy-efficient and durable housing that is resilient to extremes of heat and cold, storms, natural disasters and climate change.
31. Ensure that home, work and leisure spaces are accessible to adolescents with disabilities.
32. Ensure adequate health, education and work facilities and improve access by building roads.
33. Provide safe transportation to health, education and work facilities, including during emergencies.
34. Improve access to information and communication technologies, including mobile phones.
35. Improve road safety, including through mandatory wearing of seat-belts and cycle and motorcycle helmets.
36. Improve regulation and compliance of drivers, including introduction of a graduated driving licence that restricts driving options for inexperienced drivers.

Appendix IV. WHO Region and country income status used in 2012 Global Health Estimates analyses.

Key: HIC=High-Income Country; LMIC=Low- or Middle-Income Country

WHO African Region LMICs	
1. Algeria	
2. Angola	
3. Benin	
4. Botswana	
5. Burkina Faso	
6. Burundi	
7. Cabo Verde	
8. Cameroon	
9. Central African Republic	
10. Chad	
11. Comoros	
12. Congo	
13. Côte d'Ivoire	
14. Democratic Republic of the Congo	
15. Eritrea	
16. Ethiopia	
17. Gabon	
18. Gambia	
19. Ghana	
20. Guinea	
21. Guinea-Bissau	
22. Kenya	
23. Lesotho	
24. Liberia	
25. Madagascar	
26. Malawi	
27. Mali	
28. Mauritania	
29. Mauritius	
30. Mozambique	
31. Namibia	
32. Niger	
33. Nigeria	
34. Rwanda	
35. Sao Tome and Principe	
36. Senegal	
37. Seychelles	
38. Sierra Leone	
39. South Africa	
40. Swaziland	
41. Togo	
42. Uganda	

43. United Republic of Tanzania	
44. Zambia	
45. Zimbabwe	
WHO American Region LMICs	
1. Argentina	
2. Belize	
3. Bolivia (Plurinational State of)	
4. Brazil	
5. Colombia	
6. Costa Rica	
7. Cuba	
8. Dominica	
9. Dominican Republic	
10. Ecuador	
11. El Salvador	
12. Grenada	
13. Guatemala	
14. Guyana	
15. Haiti	
16. Honduras	
17. Jamaica	
18. Mexico	
19. Nicaragua	
20. Panama	
21. Paraguay	
22. Peru	
23. Saint Lucia	
24. Saint Vincent and the Grenadines	
25. Suriname	
26. Venezuela (Bolivarian Republic of)	
WHO Eastern Mediterranean Region LMICs	
1. Afghanistan	
2. Djibouti	
3. Egypt	
4. Iran (Islamic Republic of)	
5. Iraq	
6. Jordan	
7. Lebanon	
8. Libya	
9. Morocco	
10. Occupied Palestinian Territory	
11. Pakistan	
12. Somalia	
13. South Sudan	
14. Sudan	
15. Syrian Arab Republic	

16. Tunisia	
17. Yemen	
WHO European Region LMICs	
1. Albania	
2. Armenia	
3. Azerbaijan	
4. Belarus	
5. Bosnia and Herzegovina	
6. Bulgaria	
7. Georgia	
8. Hungary	
9. Kazakhstan	
10. Kyrgyzstan	
11. Montenegro	
12. Republic of Moldova	
13. Romania	
14. Serbia	
15. Tajikistan	
16. The former Yugoslav Republic of Macedonia	
17. Turkey	
18. Turkmenistan	
19. Ukraine	
20. Uzbekistan	
WHO Southeast Asian Region LMICs	
1. Bangladesh	
2. Bhutan	
3. Democratic People's Republic of Korea	
4. India	
5. Indonesia	
6. Maldives	
7. Myanmar	
8. Nepal	
9. Sri Lanka	
10. Thailand	
11. Timor-Leste	
WHO Western Pacific Region LMICs	
1. Cambodia	
2. China	
3. Cook Islands	
4. Fiji	
5. Kiribati	
6. Lao People's Democratic Republic	
7. Malaysia	
8. Marshall Islands	
9. Micronesia (Federated States of)	
10. Mongolia	

11. Nauru	
12. Niue	
13. Palau	
14. Papua New Guinea	
15. Philippines	
16. Samoa	
17. Solomon Islands	
18. Tonga	
19. Tuvalu	
20. Vanuatu	
21. Viet Nam	
All HICs	**WHO Region**
1. Andorra	European
2. Antigua and Barbuda	American
3. Australia	Western Pacific
4. Austria	European
5. Bahamas	American
6. Bahrain	Eastern Mediterranean
7. Barbados	American
8. Belgium	European
9. Brunei Darussalam	Western Pacific
10. Canada	American
11. Chile	American
12. Croatia	European
13. Cyprus	European
14. Czech Republic	European
15. Denmark	European
16. Equatorial Guinea	African
17. Estonia	European
18. Finland	European
19. France	European
20. Germany	European
21. Greece	European
22. Iceland	European
23. Ireland	European
24. Israel	European
25. Italy	European
26. Japan	Western Pacific
27. Kuwait	Eastern Mediterranean
28. Latvia	European
29. Lithuania	European
30. Luxembourg	European
31. Malta	European
32. Monaco	European
33. Netherlands	European
34. New Zealand	Western Pacific

35. Norway	European
36. Oman	Eastern Mediterranean
37. Poland	European
38. Portugal	European
39. Puerto Rico	Non_MS
40. Qatar	Eastern Mediterranean
41. Republic of Korea	Western Pacific
42. Russian Federation	E European
43. Saint Kitts and Nevis	American
44. San Marino	European
45. Saudi Arabia	Eastern Mediterranean
46. Singapore	Western Pacific
47. Slovakia	European
48. Slovenia	European
49. Spain	European
50. Sweden	European
51. Switzerland	European
52. Taiwan	Western Pacific
53. Trinidad and Tobago	American
54. United Arab Emirates	Eastern Mediterranean
55. United Kingdom	European
56. United States of America	American
57. Uruguay	American