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

--- SECTION 1 ONLY ---

World Health Organization, 15 December 2016

1. INTRODUCTION

KEY MESSAGES [Section 1]:

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.**

1.1. ADOLESCENT HEALTH AND DEVELOPMENT

There are 1.2 billion adolescents (aged 10 to 19 years) in the world today, representing more than one-sixth (18%) of the global population (UNICEF 2011a). As would be expected for a population that size, adolescents are extremely diverse. They differ in culture, income status, urban/rural residency, education, family and household composition, and many other ways which can have a great impact on their health and wellbeing. Nonetheless, across all societies and settings, adolescents share key developmental experiences as they transition from childhood to adulthood. These include rapid physical growth, hormonal changes, sexual development, new and complex emotions, an increase in intellectual capacities, moral development, and evolving relationships with peers and families (UNESCO 2014).

Adolescents have unique, fundamental needs related to their health and wellbeing. For example, the onset of menstruation during puberty means that adolescent girls need to be prepared and assisted to manage their menstrual hygiene, including having access to safe latrines, hygiene materials, clean water, soap, and adequate sanitation and disposal mechanisms (UNESCO 2014). In addition, a diverse array of injuries and diseases can occur during the adolescent years, although the likelihood of each may vary greatly with setting and subpopulation. These include:

- **unintentional injuries**, particularly those caused by road injury, drowning, and fire and heat;
- **interpersonal violence**, including child maltreatment, youth violence, gender-based violence, intimate partner violence, sexual assault, and violence against lesbian, gay, bisexual, transgender, or intersex (LGBTI) individuals;
- **sexual and reproductive health concerns**, particularly HIV, other sexually transmitted-infections, contraceptive needs, and maternal disorders;
- **other communicable diseases**, such as diarrheal diseases, meningitis, and lower respiratory infections;
- **non-communicable conditions**, such as congenital anomalies, leukemia, cerebrovascular disease, lower back and neck pain, asthma, and iron-deficiency anemia;
- **mental health conditions**, such as self-harm and depressive, conduct disorder, anxiety, and substance use disorders.

Many of these conditions are preventable or treatable, but are neglected and need more sustained focus and investment. Numerous important risk factors for health problems start or are consolidated during adolescence and may continue over the life course. According to Lim and colleagues (2012), five health-compromising behaviours that usually start between the ages of 10 and 24 years were among the leading twenty global causes of lost disability-adjusted life-years (DALYs) in 2010, i.e. tobacco use (ranked 2nd), diet low in fruits (4th), alcohol use (5th), physical inactivity (10th), and drug use (19th). In addition, the authors note that unprotected sex and lack of access to contraception among adolescents "would probably account for a large fraction of the global health burden", but did not meet their criteria for inclusion in the review. Two nutrition-related conditions that usually have their origins before or during adolescence also ranked in the leading twenty causes of DALYs lost globally, i.e. high body mass index (6th) and iron deficiency (13th).

One way to conceptualize the range of factors which influence adolescent health and development is through an ecological model that considers health determinants at macro, structural, environment, organizational, community, interpersonal, and individual levels. Determinants are factors which affect the health of individuals and communities, such as the social and economic environment, the physical environment, and an adolescent's individual characteristics and behaviours, e.g. income and social status, education, social support networks, genetics, health

services, and gender (WHO 2016a). Figure 1.1 illustrates how determinants may work at different levels of an ecological framework. Such a model can help identify levels at which interventions can effectively target risk or protective factors affecting adolescent health burdens.

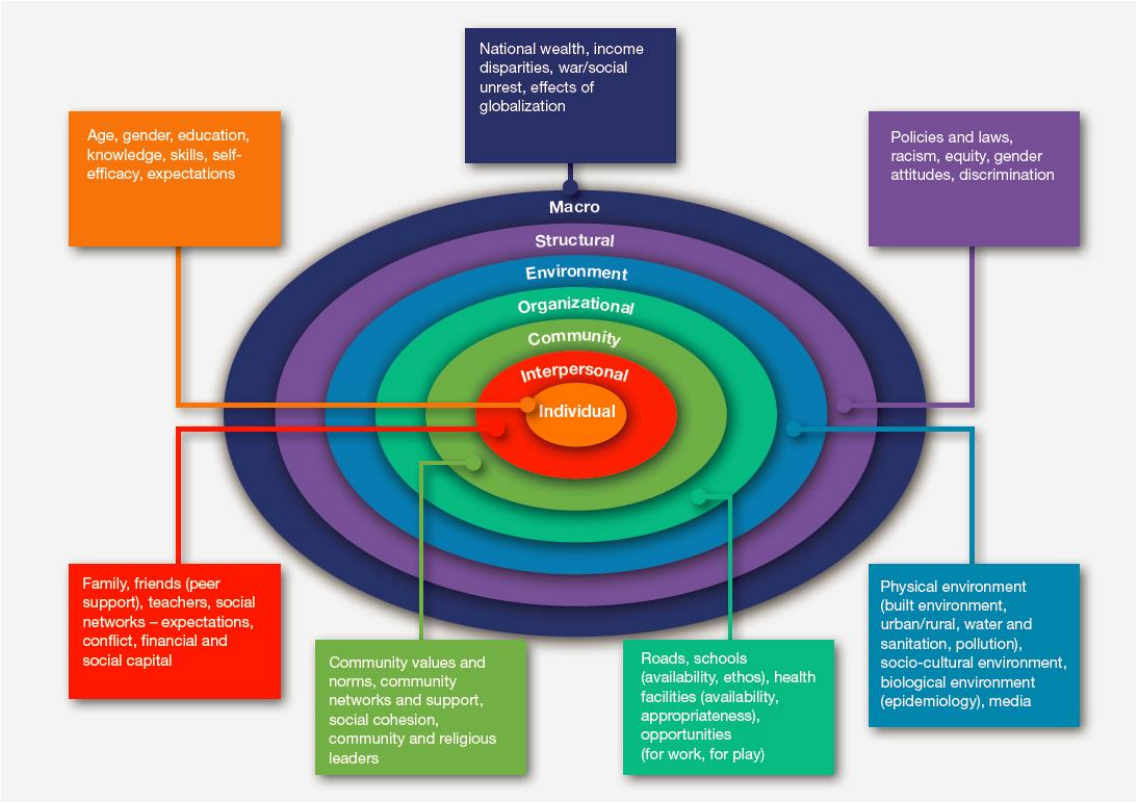

Figure 1.1. An ecological model of the determinants of adolescent health and development.
Source: WHO 2014.

1.2. WHY INVEST IN ADOLESCENT HEALTH?

There are strong demographic, public health, economic, and human rights reasons to invest in the health and the development of adolescents. Each of these is described briefly below.

1.2.1. POPULATION DISTRIBUTION AND TRENDS

Adolescent demographics provide a compelling justification to invest in their health and wellbeing. Adolescents comprise almost one-fifth of the world's population, and often they are an even larger and growing proportion of populations in low- and middle-income countries (LMICs), particularly in sub-Saharan Africa (UN Population Division 2015). An epidemiological and demographic transition occurs as a country moves from a pre-industrial to an industrialized economic system, reflected in lower birth and death rates. If a country first succeeds in reducing infant mortality, but mothers still have a high fertility rate, a disproportionately large youth population (a "youth bulge") can result. This phenomenon is sometimes associated with an increased risk of political violence (UN Population Division 2012).

Many of the countries that will see the largest increases in the number of adolescents and youth between 2015 and 2030 are already struggling to address their health needs, particularly with respect to reproductive health (UN Population Division 2015). Investment in the education and health of the current and coming generation of adolescents will benefit the entire society as the population ages. This is likely to take place through improved productivity, reduced health costs,

and enhanced social capital through increased capacity of the society to cope with unexpected shocks (UNFPA 2010).

1.2.2. PUBLIC HEALTH

Protection and improvement of the health of general populations also provides a strong argument for investing in adolescent health and development. Adolescence provides critical opportunities to:

- **Build on health investments**, that is, to maintain and expand upon successful health interventions which children benefited from in early (0-4 years) and middle (5-9 years) childhood, e.g. prenatal and safe delivery care, vaccinations, and nutrition interventions.
- **Rectify earlier health deficits**, specifically to address developmental or health shortfalls which children may have experienced during those earlier years (e.g. emotional, cognitive, and nutritional).
- **Create a triple dividend**. Two-thirds of premature deaths and one-third of the total disease burden in adults are associated with conditions or behaviours that began in youth, such as tobacco use, unhealthy diets, physical inactivity, and harmful use of alcohol (World Bank 2007). Improving the health of adolescents can result in a triple dividend (Figure 1.2). A few examples follow:
  - ***For adolescents now:*** Promotion of positive and healthy behaviours, and prevention and treatment of substance use disorders, mental disorders, injuries, and sexually-transmitted infections can immediately benefit adolescents' health and wellbeing.
  - ***For adolescents in their future adult lives:*** Prevention of obesity, alcohol use, and tobacco use in early adolescence not only promotes adolescent health and development, but are also will reduce morbidity, mortality, and disability later in life.
  - ***For the next generation****:* Nutritional deficiencies, early pregnancy, pregnancies in close succession, and female genital mutilation can have profound effects on an adolescent or her later pregnancies, including outcomes related to foetal and infant development, neonatal and early childhood mortality, and stunting in childhood.

Selected health problems during adolescence	Age when Health Problem has its Major Impact		
	Adolescence →	Adulthood →	Childhood (next generation)
Accidents and violence	+++	+	+
Adolescent pregnancy	++	++	++
Depression	++	++	+
Human papilloma virus	+	+++	
Water-based helminths	+	++	
Tobacco use	+	+++	+
Alcohol use	++	++	+
HIV	++	+++	++

Figure 1.2. Impact of select health problems during adolescence on health during adolescence, adulthood, and the next generation.
Source: WHO 2014.

1.2.3. ECONOMIC BENEFITS

Adolescent health and development problems have great economic costs (UNFPA 2010). For example, a study of fourteen LMICs found that the cost of adolescent pregnancy as a share of gross domestic product ranged from 1% to 30% over a girl's lifetime, depending on the assumptions used to calculate the losses (World Bank 2011). In general, preventative programs can be substantially more cost-effective and equitable than acute treatments, so investment in women's, adolescents', and children's health can secure high economic returns (Deogan et al. 2012; Stenberg et al. 2014). For instance, it has been estimated that an increase of health expenditure of just five US dollars per person per year up to 2035 in 74 high-burden countries could yield up to nine times that value in economic and social benefits (Stenberg et al. 2014).

In addition, returning to the question of demographic and epidemiological transitions, improved adolescent health in LMICs that results in declines in mortality and fertility rates will contribute towards accelerated economic growth. With fewer births each year, a country's young dependent population grows smaller in relation to the working-age population (aged 15-64 years), creating a window of opportunity for rapid economic growth (Population Reference Bureau 2012). Currently, the working-age population is believed to have reached its peak in Asia, Latin America, and the Caribbean, and it is declining in Europe, North America, and Oceania, but the proportion of the African population in this age group is expected to increase between 2015 and 2030 (UN Population Division 2015).

1.2.4. HUMAN RIGHTS

Adolescents not only have basic needs but also fundamental rights to life, survival, maximum development, health, and access to health services (UN 1989; UN CRC 2003; UN CRC 2016). A rights-based argument for investment in adolescent health focuses on the obligations of governments and other duty-bearers (e.g. according to existing international agreements); equity; interventions and policies that are needed but are culturally sensitive and controversial (e.g. sexuality education and informed consent); and listening to and engaging with adolescents (WHO 2014). The primary instrument for protecting and fulfilling these rights is the United Nations Convention on the Rights of the Child (CRC) (UN 1989). The CRC reflects the international consensus on standards for ensuring the overall wellbeing of all children up to the age of 18 years. In 2003, the UN CRC also specifically addressed adolescent health and developmental needs in its General Comment No. 4 (UN CRC 2003).

In all countries, there are certain subpopulations of adolescents who experience greater exposure and vulnerability to risk factors, lesser access to health services, worse health outcomes, and greater social consequences as a result of ill health. Inequities are often seen among groups characterized by sex, income, education, rural/urban residence, and other factors (WHO 2016b). Consideration of adolescent health rights thus fundamentally includes examination of equity, and specifically which adolescents might be most vulnerable and at-risk in different settings. These might include adolescents who are living with disabilities or chronic illnesses (e.g. sickle cell anaemia; HIV); those living in remote areas or caught up in social disruption from natural disasters or armed conflicts (e.g. refugees); and those who are stigmatized and marginalized because of sexual orientation or ethnicity, who are institutionalized or exposed to domestic violence or substance abuse in the family, who do not have access to education, health services or social protection (e.g. poor urban and rural residents), and/or who are exploited and abused (e.g. homeless adolescents) (UNFPA 2010; Sonenstein 2014; Global Early Adolescent Study 2015; WHO 2016b).

A critical issue to consider within human rights and equity is the role of gender and how it impacts on adolescent health. "Gender" refers to socially constructed male and female characteristics, such as norms, roles, and relationships of and between groups of adolescent girls and boys (WHO 2016c). Gender norms, roles, and relations often contribute to enhanced vulnerability of adolescent girls adolescent girls. For instance, marginalized adolescent girls bear burdens of discrimination and human rights violations that often affect their health and wellbeing, including girls who are affected by harmful traditional practices; do not have adequate protection; or are excluded from education (UN Interagency Taskforce on Adolescent Girls 2009). Girls who are married or who work in domestic service are examples of socially isolated girls whose needs are often overlooked and whose behaviour may be dictated by others, to their detriment (e.g. access to health care, or rapid repeat pregnancy) (UNFPA 2010). Gender roles may also detrimentally influence the health of adolescent boys; for example, social norms of masculinity may contribute to risk-taking and resultant injuries (WHO 2000).

1.3. GLOBAL ACCELERATED ACTION FOR THE HEALTH OF ADOLESCENTS (AA-HA!): IMPLEMENTATION GUIDANCE

The Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) lists many evidence-based interventions separately for women, children, and adolescents (EWEC 2015). 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). Section A1.1 in Annex 1 describes more about the Global Strategy, including the 26 Global Strategy interventions for children and adolescents which are directly relevant to adolescent health, and the one composite intervention that represents the 48 maternal health interventions.

This Global Accelerated Action for the Health of Adolescents (AA-HA!) Implementation Guidance document was developed to support the Global Strategy by providing countries with a basis for developing a coherent national plan for the health of adolescents. Global AA-HA! development was initiated and led by the WHO Department of Maternal, Newborn, Child and Adolescent Health. From October 2015 to February 2017, the Global AA-HA! Implementation Guidance document was developed, reviewed, and refined based on the input of many stakeholders. Consultations included:

- On-going draft review and feedback from key WHO departments.
- On-going draft review, and a global meeting involving an external advisory group of thirty non-WHO members representing: Ministries of Health of selected Member States in the six WHO Regions; UN agencies and partners (e.g. the International Association for Adolescent Health); civil society (including youth and youth-serving organizations); and academia.
- Consultation meetings with national-level programme managers, policy makers, and adolescents and young adults in each WHO region.
- A series of focus group workshops conducted with young and/or vulnerable adolescents in the six WHO Regions.
- Secondary data analysis of health themes in the Global Early Adolescent Study.
- An initial online and in-person survey conducted early in the Global AA-HA! development process.

- A global consultation on the penultimate draft of the Global AA-HA! Implementation Guidance document, including a second online survey.

Section A1.2 in Annex 1 describes more about the Global AA-HA! Implementation Guidance development process, including: the initial online and in-person survey; assessment of adolescent health based on the 2012 Global Health Estimates; review and selection of evidence-based interventions; and adolescent participation.

The remainder of this document addresses the following topics:

- 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.

In total, 64 country case studies are provided across Sections 3-6 and their accompanying Annexes. These 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 Section A1.2.5 in Annex 1.

1.4. KEY CONCEPTS IN ADOLESCENT HEALTH PROGRAMMING

There are many ways to conceptualize, structure, or approach adolescent health interventions and programming. Three critical, overarching, and inter-related concepts are universal health coverage, equity, quality of care, and positive development, each of which is described briefly below. Section A1.3 in Annex 1 provides a glossary of other key terms used in this document.

1.4.1. UNIVERSAL HEALTH COVERAGE

Two fundamental concepts make up the goal of universal health coverage for adolescents: first, all adolescents should receive the quality health services they need, and second, they should not suffer stigma or financial hardship in the process (WHO 2013a). To achieve this goal, several factors must be in place, including: affordability; access to essential medicines and technologies; social and community support for adolescent health; sufficient capacity of well-trained, motivated health workers; and a strong, efficient, cohesive, and accessible health system that meets priority adolescent health needs through prevention, early detection, treatment, and rehabilitation. Universal health coverage positions equity as a central issue in health and directly reflects two of the Sustainable Development Goals (SDGs), that is: SDG no. 3, which focuses on ensuring healthy lives for all, and SDG no. 10, which calls for a reduction in inequality within and between countries to promote the inclusion and empowerment of all.

1.4.2. QUALITY OF CARE

The WHO “quality of care” framework broadly identifies key elements in the provision of adolescent-friendly health care. Such services should be:

- **Equitable:** All adolescents, not just certain groups, are able to obtain the health services they need.

- **Accessible:** Adolescents are able to obtain the services that are provided.
- **Acceptable:** Health services are provided in ways that meet the expectations of adolescent clients.
- **Appropriate:** The right health services that adolescents need are provided in ways that account for issues such as privacy, confidentiality, non-stigmatization, and gender-responsiveness.
- **Effective*:*** The right health services are provided in the right way, and make a positive contribution to the health of adolescents. (WHO 2006; WHO 2012).

In 2015, WHO and UNAIDS published much more detailed guidelines on global standards for quality health care services for adolescents, focusing on standards and criteria, implementation, measurement tools, and scoring sheets (WHO and UNAIDS 2015a; WHO and UNAIDS 2015b; WHO and UNAIDS 2015c; WHO and UNAIDS 2015d). These are practical resources for countries. For example, the implementation guidelines recommend specific actions at the national, district, and facility level related to governance, workforce capacity, financing, and drugs, supplies and technology (WHO and UNAIDS 2015b).

1.4.3. POSITIVE DEVELOPMENT

Adolescent health and wellbeing is based on positive physical, neurological, and psychosocial development (WHO 2004; UNICEF 2011b; WHO 2014). 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). 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. 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.

A positive approach to adolescent development recognizes adolescents as sources of opportunity rather than problems (UNICEF 2014). For example, programs which promote positive adolescent psychosocial development employ strategies to build social-emotional and life skills, foster positive behaviour, discourage negative behavior, promote engagement in civil society, and enhance the wellbeing of adolescents as they transition to adulthood (USAID 2013). This approach builds developmental skills which have been associated with adaptive behaviors, such as school achievement and pro-social engagement. Although the emphasis of such programs is on promoting the healthy adjustment of all youth through effective and empowering learning environments, some programs specifically target marginalized and excluded youth who have fewer skills, opportunities, and resources available to them.

References [Section 1]:

Deogan, C., J. Ferguson, and K. Stenberg. 2012. Resource needs for adolescent friendly health services: Estimates for 74 low- and middle-income countries. PloS ONE 7(12):e51420.

EWEC (Every Woman Every Child). 2015. The Global Strategy for Women's Children's and Adolescents' Health (2016-2030).

Global Early Adolescent Study. 2015. The Global Early Adolescent Study: An exploration of the evolving nature of gender norms and social relations: 10-14 years: A critical age.

Lim, S. S. et al. 2012. A comparative risk assessment of burden of disease and injury attributable to 67 risk factors and risk factor clusters in 21 regions, 1990–2010: A systematic analysis for the Global Burden of Disease Study 2010. Lancet 380:2224–60.
Population Reference Bureau. 2012. The challenge of attaining the demographic dividend: Policy brief, September 2012.
Sonenstein, F. L. 2014. Editorial: Introducing the Wellbeing of Adolescents in Vulnerable Environments Study: Methods and findings.
Stenberg, K. et al. 2014. Advancing social and economic development by investing in women's and children's health: A new global investment framework.
UN Population Division 2012. A clash of generations? Youth bulges and political violence: Expert Paper No. 2012/1.
UN Population Division 2015. Population 2030: Demographic challenges and opportunities for sustainable development planning (ST/ESA/SER.A/389).
UN CRC (Convention on the Rights of the Child). 2003. General comment No. 4, adolescent health and development in the context of the Convention on the Rights of the Child. UN Document CRC/GC/2003/4.
UN CRC (Convention on the Rights of the Child). 2016. General comment on the implementation of the rights of the child during adolescence, April 2016 [DRAFT]. http://www.ohchr.org/EN/HRBodies/CRC/Pages/childduringadolescence.aspx.
UN Interagency Taskforce on Adolescent Girls. 2009. Girl power and potential: A joint programming framework for fulfilling the rights of marginalized adolescent girls.
UN. 1989. Convention on the Rights of the Child: Adopted and opened for signature, ratification and accession by General Assembly resolution 44/25 of 20, November 1989, entry into force 2 September 1990, in accordance with article 49.
UNESCO. 2014. Puberty education and menstrual hygiene management: Good Policy and Practice in Health Education Booklet 9.
UNFPA. 2010. The case for investing in young people as part of a National Poverty Reduction Strategy.
UNICEF. 2011a. The state of the world's children: Adolescence: An age of opportunity.
UNICEF. 2011b. Adolescence: An age of opportunity. The state of the world's children 2011.
UNICEF. 2014. Accelerating programming for and with adolescents: UNICEF 2014-2017 Strategic Plan: January 2014.
USAID. 2013. State of the field report: Holistic, cross-sectoral youth development: USAID youth research, evaluation, and learning project: Final report, February 2013.
WHO and UNAIDS. 2015a. 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 1: Standards and criteria.
WHO and UNAIDS. 2015b. 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.
WHO and UNAIDS. 2015c. 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 3: Tools to conduct quality and coverage measurement surveys to collect data about compliance with the global standards.
WHO and UNAIDS. 2015d. 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 4: Scoring sheets for data analysis.
WHO. 2000. What about boys? A literature review on the health and development of adolescent boys.
WHO. 2004. Risk and protective factors affecting adolescent reproductive health in developing countries.
WHO. 2006. Quality of care: A process for making strategic choices in health systems.

WHO. 2011. Gender mainstreaming for health managers: a practical approach. Geneva: World Health Organization. Available: http://www.who.int/gender-equity-rights/knowledge/health_managers_guide/en/.
WHO. 2012. Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services.
WHO. 2013a. Arguing for universal health coverage.
WHO. 2014. Health for the world's adolescents: A second chance in the second decade.
WHO. 2016a. The determinants of health. http://www.who.int/hia/evidence/doh/en/.
WHO. 2016b. Innov8 approach for reviewing national health programmes to leave no one behind: technical handbook.
WHO. 2016c. Gender. http://www.who.int/gender-equity-rights/understanding/gender-definition/en/.
World Bank. 2007. World development report: Development and the next generation.
World Bank. 2011. Measuring the economic gain of investing in girls: The girl effect dividend. Policy Research Working Paper 5753.
enhagen, WHO Europe, 2010.