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

--- SECTION 4 ONLY ---

World Health Organization, 15 December 2016

4. NATIONAL PRIORITIZATION

KEY MESSAGES [Section 4]:

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.**

Until recent decades, most adolescent health services were subsumed under those for children or adults in different sectors within countries, including adolescent health promotion, risk reduction, and clinical services (Millstein et al. 1994; Alderman et al. 2003). By the 1980s, however, countries began developing and implementing adolescent-specific national health programming, partly due to growing awareness of the great SRH problems faced by adolescent populations. The sensitive and sometimes controversial nature of puberty and adolescent sexuality meant that these issues often were inadequately addressed in existing child and adult services. Efforts varied greatly within and between countries and regions, but over the years many countries have succeeded in

developing and implementing at least basic SRH education in schools at scale, and the provision of more limited youth-friendly SRH services and commodities, mostly through health facilities.

Adolescent SRH programming remains critically important in all countries, and will continue to be so in the future to best meet the needs of each new cohort of adolescents. However, in recent decades it has become increasingly evident that other adolescent health concerns also have been neglected and warrant country-level programming (WHO 1998). These include the causes of disease and injury outlined in Section 2, as well as broader social, educational, and economic issues related to adolescent health, development, and wellbeing. These issues may:

- be specific to adolescents (e.g. difficulties with psychosocial development),
- affect adolescents disproportionately (e.g. maternal mortality, STIs),
- have major implications for adolescents' future health (e.g. tobacco use, poor diet), or
- affect adolescents less than small children, but more than adults (e.g. malnutrition, malaria). (WHO 1998)

Many governments have recognized that diverse and complex adolescent health needs require coordinated, multi-sectoral, country-level programming. Some have undertaken situation analyses to identify the most urgent adolescent health concerns and determinants, as well as the most at-risk adolescent populations within their countries, in order to prioritize the allocation of resources to better meet their needs (WHO EMRO 2012). To assist national governments in this process, EWEC has drafted a document entitled, "Technical Guidance for Prioritizing Adolescent Health Interventions" (EWEC Working Group #1 2016). That document outlines steps which should be the basis for strategic decision-making on national adolescent health programming, including:

- **Step 1: 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 adolescent disease burdens and quality of life in a particular country, both among adolescents in general and among those most at risk for health problems. It also accounts for differences between girls and boys and between younger and older adolescents.
- **Step 2: A landscape analysis** reviews existing adolescent health programmes and policies as well as related legislation, capacity, and resources within the country. It should also examine the barriers to services that vulnerable subpopulations of adolescents may face. In addition, the landscape analysis should review current global guidance on which interventions are the most evidence-based and effective to address the conditions identified in the needs assessment.
- **Steps 3: A prioritization exercise** identifies (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 need for gender-responsive programming, 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.

Time, human resource capacity, and funding often will dictate the level and depth that these steps will take. Each step is described more after the case study below.

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

In 2009, the Zambian Ministry of Health and its partners conducted an adolescent health situation analysis to support appropriate national policy, planning, and response. The needs assessment identified the main adolescent health determinants, risk factors, and disease burdens as general health problems (e.g. malaria; TB and other non-pneumonia respiratory infections; diarrhea; and undernutrition); HIV, syphilis, and other STIs; early and unprotected sex; sexual abuse; early marriage and pregnancy; drug and alcohol abuse; accidents and violence; unsafe cultural practices; and mental health problems. The landscape analysis also detailed existing government efforts to provide adolescent health services, such as development of a national youth policy; establishment of a youth ministry; introduction of legislation addressing sexual, drug, and alcohol abuse; establishment of adolescent-friendly health services in pilot districts; and strengthening of the adolescent health institutional framework within the Ministry of Health organizational structure. The adolescent health situation analysis report that summarized these findings became the basis for the Ministry of Health's Adolescent Health Strategic Plan (2011-2015), which outlined strategies related to service delivery, health workforce, medical products, health information, healthcare financing, and leadership and governance. For example, the plan called for improved linkages between the ministries of health and education, especially related to health promotion in schools, as well as scale-up of the existing adolescent-friendly health service programme, including improved health worker training and supervision.

Sources: Republic of Zambia Ministry of Health and WHO 2009; Republic of Zambia Ministry of Health 2012.

4.1. NEEDS ASSESSMENT

A national adolescent health needs assessment involves a systematic review of the health status and wellbeing of adolescents in that country (EWEC Working Group #1 2016). When possible, this assessment should include a review of available data disaggregated by sex, age subgroups, education level, school status, literacy level, marital status, location (e.g. urban vs. rural), living arrangements, and other variables that may be important within the local context, e.g. ethnicity. It is critical that the reviewers attempt to find and consider all possible data with an mind open to what the best evidence suggests, even if it goes against their preconceived ideas, or those which are widely reported. For example, if a researcher begins the process by limiting it to certain health conditions (e.g. SRH, nutrition, and unintentional injury), the search may miss other conditions which have equal or greater impact on adolescent mortality and morbidity (e.g. abuse or mental health problems).

Based on the most recent, accurate, and representative research, the needs assessment should identify the main causes of adolescent mortality and morbidity, disease prevalence, and contributing risk and protective factors. It should also consider relevant issues that may not be captured well in those measures and existing research, such as levels of female genital mutilation, non-HIV sexually-transmitted infections, employability, and household income. Specifically, the needs assessment should examine:

- the main health challenges affecting adolescents;
- the adolescent behaviors most proximately linked to these health challenges;
- the adolescent behaviors that could lead to and result in health problems in the future (e.g. risk factors including tobacco consumption, poor nutrition);
- harmful practices affecting adolescents (e.g. levels of child marriage, female genital mutilation);

- the socio-cultural context of adolescents' lives, including the protective and risk factors at various ecological levels and in different institutions (e.g. schools, health services, employment) that can influence the above issues;
- the influence of gender norms, roles, and relations on adolescent health of both girls and boys; and
- the supply and demand barriers experienced by adolescents with regard to access to quality services and financial protection. (EWEC Working Group #1 2016)

One important objective of the needs assessment is to identify subgroups of adolescents who may be in greatest needs of services and programmes. Section 2 of this document provides an example of an adolescent health needs assessment at a global level.

The government should provide safe places, like public libraries. I do not know why I always feel the government takes more care of boys than girls. It should carry out activities that are good for us also.

- Young adolescent girl in the occupied Palestinian territories

The methodology of a country's adolescent health needs assessment can include desk review of available national and sub-national studies, peer-reviewed articles, and other country assessments; analysis of existing country-level disaggregated data; and focus group discussions and interviews with key stakeholders. Key stakeholders include adolescents and young adults, parents and families, community members, religious leaders, government representatives (e.g. from health, education, and social protection sectors), NGO and civil society representatives, UN technical organizations, and bilateral and donor organizations.

Figures 4.1 and 4.2 provide examples of data which can be compiled in a country-level adolescent health needs assessment, drawing on research in Nigeria from Global Burden of Disease studies between 1990 and 2013, and other sources (Patton et al. 2016). Figure 4.1 demonstrates that 10-24 year old Nigerian females carry a greater burden of SRH problems than their male counterparts, while the reverse is the case for unintentional injuries. In both groups, infectious diseases are declining over time, but still represent a great burden. The breakdown of specific results for those broad health categories highlight conditions which might be in greatest need of adolescent health programming in Nigeria, e.g. malaria and neglected tropical diseases predominate among infectious diseases, as maternal disorders do among female SRH problems. Figure 4.2 instead summarizes social determinants and risks related to adolescent health and wellbeing. It demonstrates that social determinants of health (e.g. early marriage and childbirth, under-education, and unemployment) have all improved over time, but the current levels remain unacceptably high, e.g. average years of education are below the ten recommended for basic education. Figure 4.2 also shows that, while some health risks are declining among 10-24 year olds (e.g. tobacco smoking), others have increased in recent decades (e.g. obesity and overweight; binge drinking). In addition, substantially higher proportions of Nigerian girls than boys report experience of sex before the age of 15 years, no condom use at last high risk sex, and intimate partner violence.

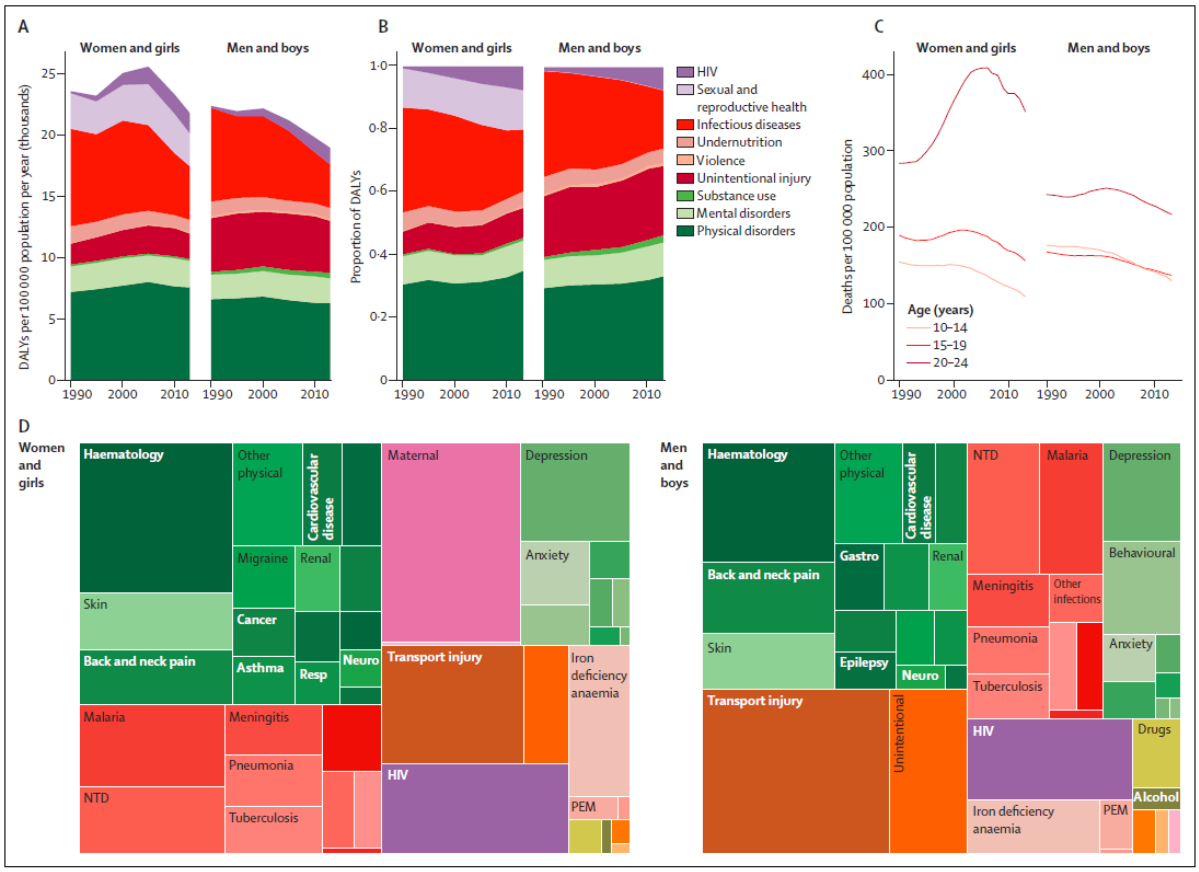

Figure 4.1. Disease burdens among 10-24 year old males and females in Nigeria, based on 1990-2013 GBD studies.

Key: (A) DALYs per 100,000 10-24 year olds, by cause and sex, 1990-2013. (B) Proportion of DALYs across nine categories by sex in 10-24 year olds, 1990-2013. (C) Deaths per 100,000 10-24 year olds per year, 1990-2013. (D) Causes of DALYs in 10-24 year olds, 2013, by sex. DALYs = disability-adjusted life-years. NTD = neglected tropical diseases. PEM = protein energy malnutrition.

Source: Patton et al. 2016.

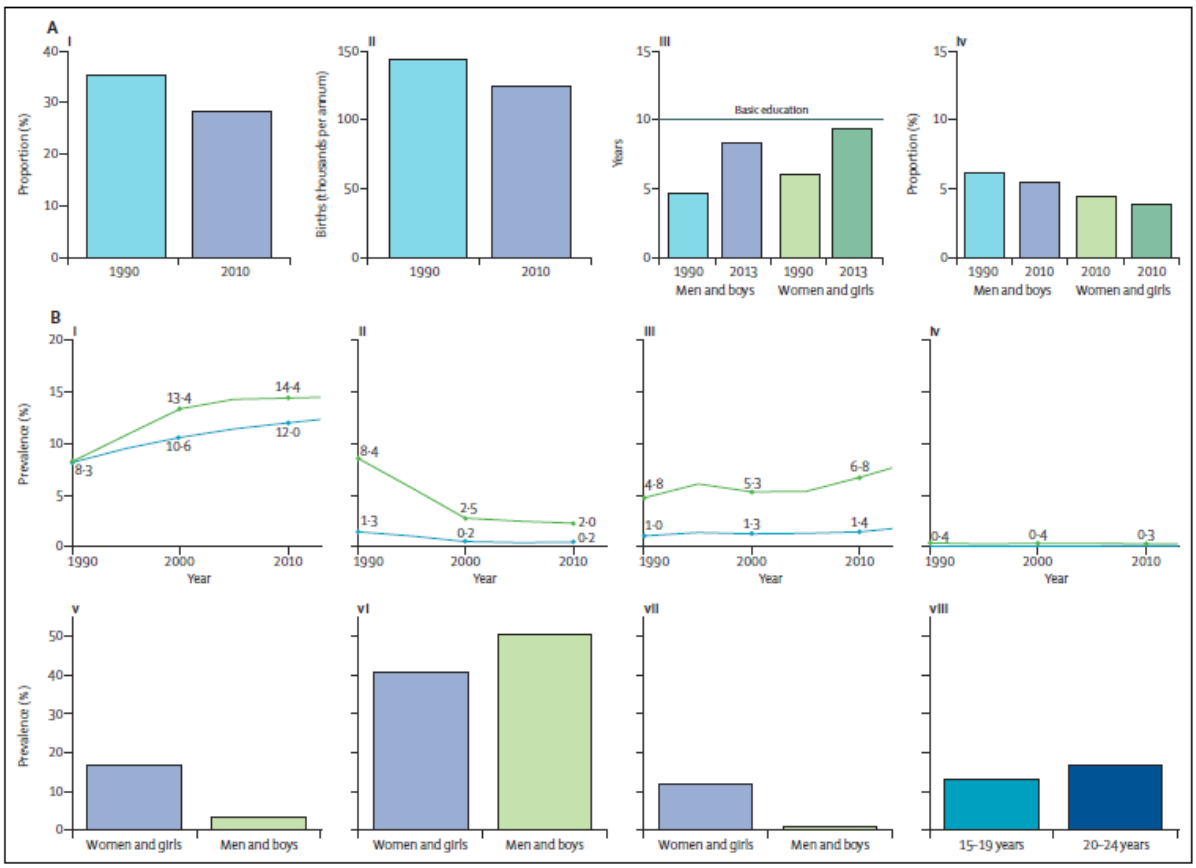

Figure 4.2. An overview of Nigeria's health profiles for 10-24 year olds.
Key: (A) Social determinants: (i) currently married females aged 15–19 years; (ii) birth rate in adolescent girls; (iii) mean years of education attained in 15–24 year olds; and (iv) unemployment in 15–24 year olds. (B) Health risks for 10-24 year olds: (i) overweight and obesity; (ii) daily tobacco smoking; (iii) binge drinking in the past 12 months; (iv) lifetime use of injectable drugs; (v) reporting sex before age 15 years (2004–14); (vi) reporting condom use at last occasion of high risk sex (2004–14); (vii) intimate partner violence (2013); and (viii) unmet need for contraception in females in a married or in civil union (2009–14). DALYs=disability-adjusted life-years. NCD=non-communicable diseases.
Source: Patton et al. 2016.

4.2. LANDSCAPE ANALYSIS

A national adolescent health landscape analysis fulfils several purposes:

- First, a landscape analysis should identify and map existing programmes, legislation, policies, and projects that address adolescent health and development, as well as the results and outcomes of these programmes. For example, this review should include laws about the age of marriage, and access to family planning by married and unmarried minors.
- Second, a landscape analysis should identify the stakeholders and organizations involved in planning, managing, implementing, and monitoring and evaluating these activities at the national and sub-national level. It should also identify the systems that are in place to support capacity development, supportive supervision, coordination, and other planning and management functions. Crucially, it should examine how adolescents and youth participate in and contribute to these efforts, and the systems or platforms in place for them to do so.
- Third, the landscape analysis should identify existing and potential sources of financing (both domestic and international) and current budgetary allocations, especially considering how they meet the required needs.

- Fourth, the landscape analysis should review current global adolescent health intervention recommendations, and particularly those which have a strong evidence base, so national governments can assess which existing programmes should be maintained or strengthened based on evidence of effectiveness, and which possibly should not be. (EWEC Working Group #1 2016)

At the country level, a landscape analysis assesses what is being done by the government, NGOs, and CSOs to improve adolescent health and to respond to social, economic, and other determinants of adolescents' health problems. It should include coverage studies of the reach and quality of existing programmes and services. Like the needs assessment, the landscape analysis can involve a desk review, field visits, and interviews and focus group discussions with young people and other key informants. Key informants can explain existing programme challenges and successes, perceptions of needs and services, and the capacity and interest for expanded work on adolescent health.

The draft EWEC guidance document summarizes important questions to address in such a landscape analysis, including:

- the extent to which the national health plan integrates adolescents in its goals and programming;
- specific laws or policies that may impede adolescents' access to health services;
- gaps in the delivery of programmes and services;
- scale, scope, coverage, and evidence of impact of existing adolescent health programmes in the country;
- how interventions in relevant sectors are targeted to reach particular groups of adolescents by age, sex, location, education level, and other sociodemographic variables;
- the level of funding to existing programmes and how available funds are allocated;
- whether currently-funded activities are aligned with evidence-based practices; and
- the extent to which youth are involved in the design, implementation, and monitoring of the specified programmes.

Returning to the example of Nigeria, a country adolescent health landscape analysis might highlight its low density of health workers and need for scale-up of health service coverage related to adolescent maternal health, contraception, HIV treatment, treatment for other infectious diseases, and chronic physical problems (Patton et al. 2016). The assessment might also note that certain conditions (e.g. road injury, obesity) are increasing in prevalence among adolescents and may require more targeted policy, legislative, and programmatic responses, and that education sector capacity-building and expansion could be critical to implementing adolescent health promotion efforts at scale.

4.3. PRIORITIZATION EXERCISE

Steps 3 of a country's adolescent health situation analysis involves a prioritization exercise to identify which conditions to target, and which set of interventions to employ in targeting them (EWEC Working Group #1 2016). This process of strategically narrowing the focus of adolescent health interventions is necessary because young people aged 10-19 years represent such a large and diverse population with many needs. Given governments often face significant resource constraints, they may need to make difficult choices to effectively address top priorities.

The prioritization process requires a systematic approach and should use a transparent set of criteria. All relevant stakeholders should be consulted in a structured manner. The draft EWEC

guidance document suggests governments consider the following criteria and any others they deem important in identifying priority adolescent vulnerabilities and health issues:

1. *Magnitude of the issue:* Resources must be directed at the main causes of death and illness/injury, but also must go beyond this to address behaviours and exposures that could affect adolescents' health now and in the future, using a life course approach.
2. *Groups of adolescents most affected:* All adolescents have health-related needs and can experience difficulties, but not all are equally vulnerable to health and social problems. Some adolescents have overlapping vulnerabilities that make them particularly at risk of the poorest health outcomes (e.g. low education, impoverishment, and living in communities with high rates of child marriage).
3. *Availability of effective interventions*: It is important that scarce resources be used to deliver interventions that have the highest chance of effectiveness for the subpopulations of adolescents that need them the most. Proposed interventions should be guided by the strongest available evidence, recognizing that research is on-going to identify the most effective interventions and ways to deliver them.
4. *Feasibility of delivering interventions:* Social, economic, and cultural constraints, including lack of recognition for adolescents' rights, may make it difficult to deliver certain interventions. Priority setting must be based on a careful and pragmatic analysis of the feasibility of delivering interventions in the particular country with fidelity and at scale.
5. *Potential to go to scale:* An assessment of current and needed capacity to deliver the interventions is necessary. Strong government and community ownership and political will help drive expansion. Costing exercises can inform overall resource needs, and how plans can be implemented in a phased approach.

Returning to the Nigerian example described in Sections 4.1 and 4.2, possible priority health actions for 10–24 year olds include:

- sexual and reproductive health (e.g. CSE; promotion of condom use and voluntary medical male circumcision; contraception and maternal health services; HIV testing, treatment, and care; and enforcement of legislation prohibiting child marriage);
- infectious diseases (e.g. access to quality health services, vaccinations and bed net provision);
- improved WASH and nutrition (e.g. school health programmes);
- unintentional injury (e.g. legislation for graduated licensing, motorcycle helmet use, speed control, pedestrian safety measures, and alcohol and driving control; access to high quality trauma care); and
- physical disorders and non-communicable disease risks (e.g. adolescent-friendly health services; prevention of overweight through taxation of unhealthy foods, restriction of fast food advertising, and promotion of physical activity) (Patton et al. 2016).

The prioritization process should include development of a logic model that links planned interventions to the determinants, behaviours, and health outcomes they intend to affect within the particular country context (Kirby 2004). It should result in a strategy that includes and identifies a package of priority interventions, a set of mechanisms to deliver them, the means available to deliver them, and a monitoring and evaluation plan (EWEC Working Group #1 2016). The health sector alone cannot be responsible for all of the policies and programmes that will need to be implemented, but it can play a lead role in the multi-sectoral response, facilitating and mobilizing the essential actions of other sectors, strengthening technical support and coherence, and disseminating epidemiological information and the evidence base for action.

Critically, over time it is important for countries to re-visit this three step process of needs analysis, landscape analysis, and prioritization, in order to best meet changing adolescent health needs. In addition, there may be times when a country or region needs to implement rapid and focused adolescent health prioritization exercises, as in the event of a humanitarian crisis. Box 4.1 provides an example of how to conduct an adolescent SRH situation analysis in humanitarian and fragile settings.

Box 4.1. Adolescent sexual and reproductive health situation analysis in humanitarian and fragile settings.

In a humanitarian and fragile setting, it is important to conduct research to understand the SRH situation of both male and female adolescents, in order to develop a plan that responds to their specific needs. The 2009 "Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings" provides tools for initial rapid assessment, situation analysis, and comprehensive SRH surveys of adolescents in emergency situations. Specifically:

- **An initial rapid assessment** should be conducted during the first 72 hours of an acute emergency and be used to collect demographic information and identify life-saving issues that must be addressed urgently to ensure the wellbeing of the beneficiary population.
- **A situation analysis** conducted after an emergency situation has stabilized will provide information about the baseline status of RH needs and services, and will help in the prioritization of interventions when comprehensive SRH services are introduced. Situation analyses may use several methods of data collection, including secondary data, in-depth interviews, focus-group discussions (sex-separated, if culturally required), community mapping, and facility assessments.
- **Comprehensive SRH assessments** are not often conducted in emergency situations because they are time-consuming and they can place additional burdens on precious human and logistic resources. After stabilization of an acute emergency, however, a comprehensive assessment of SRH knowledge, beliefs and behaviors, can provide valuable information that will help an agency design an SRH program that responds to the specific gendered needs of the beneficiary population.

Although the assessments and analyses above are valuable in a humanitarian crisis, it is important to remember that the minimum initial service package should be the first SRH intervention to be introduced, and should never be delayed while waiting to conduct research.

Source: Save the Children and UNFPA 2009.

Annex 4 provides additional information for consideration in national prioritization of adolescent health programming. Specifically:

- **Section A4.1** describes additional resources to support national prioritization processes, including a manual for health planners and researchers conducting a rapid assessment of adolescent health needs (WHO WPRO 2001), and a regional guide on conducting an adolescent health situation analysis (WHO EMRO 2011).
- **Section A4.2** describes three additional case studies of countries which have implemented adolescent health needs assessments, landscape analyses, and/or prioritization exercises to inform their national programming.
- **Section A4.3** draws on country-specific adolescent mortality data to illustrate how individual countries - even neighbouring countries within the same region – may have very different priorities based on the available data.

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