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

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World Health Organization, 13 December 2016

ANNEX 5. ADDITIONAL INFORMATION ABOUT NATIONAL PROGRAMMING

A5.1. DATA FROM THE GLOBAL MATERNAL, NEWBORN, CHILD AND ADOLESCENT HEALTH POLICY INDICATOR SURVEYS (2009-10, 2011-12, 2013-14, 2016)

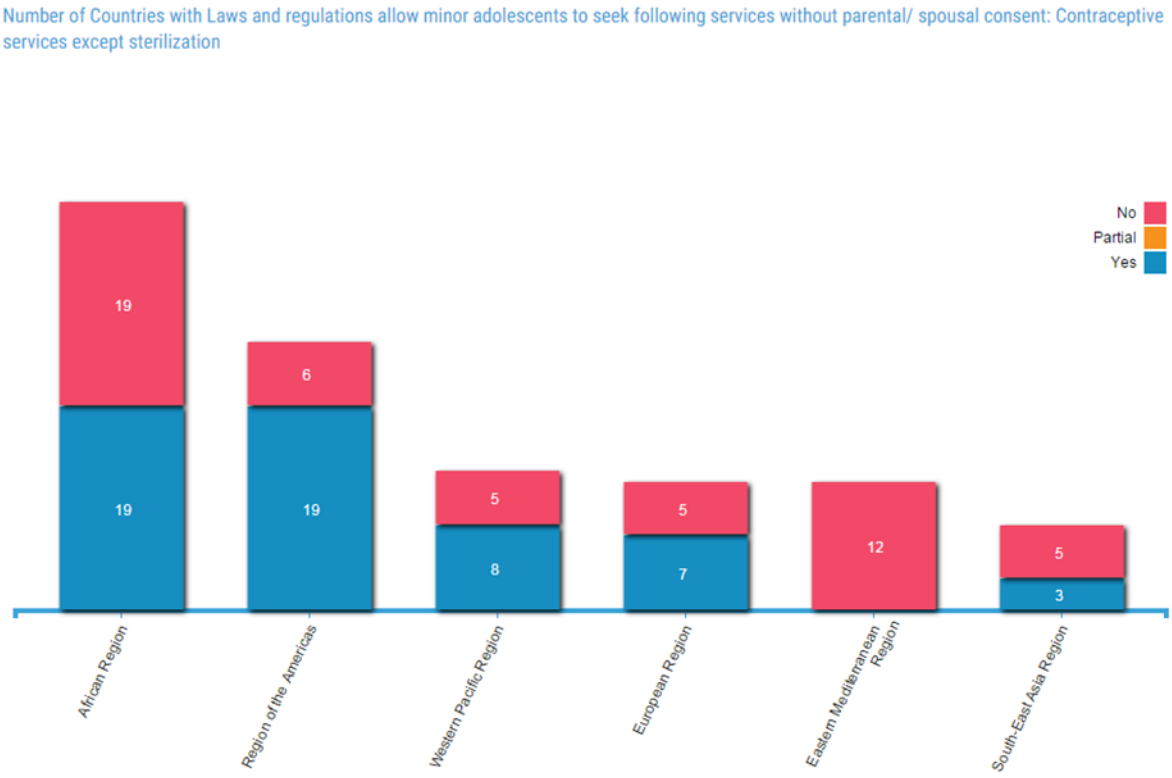

Figure 5.1. Number of countries with laws and regulations that allow adolescent minors (less than 18 years of age) to seek contraceptive services (except sterilization) without parental/spousal consent.

Source: Information from countries that responded to the Global Maternal, Newborn, Child and Adolescent Health Policy Indicator Surveys (2009-10, 2011-12, 2013-14, 2016) undertaken by Department of Maternal, Newborn, Child and Adolescent Health; World Health Organization.

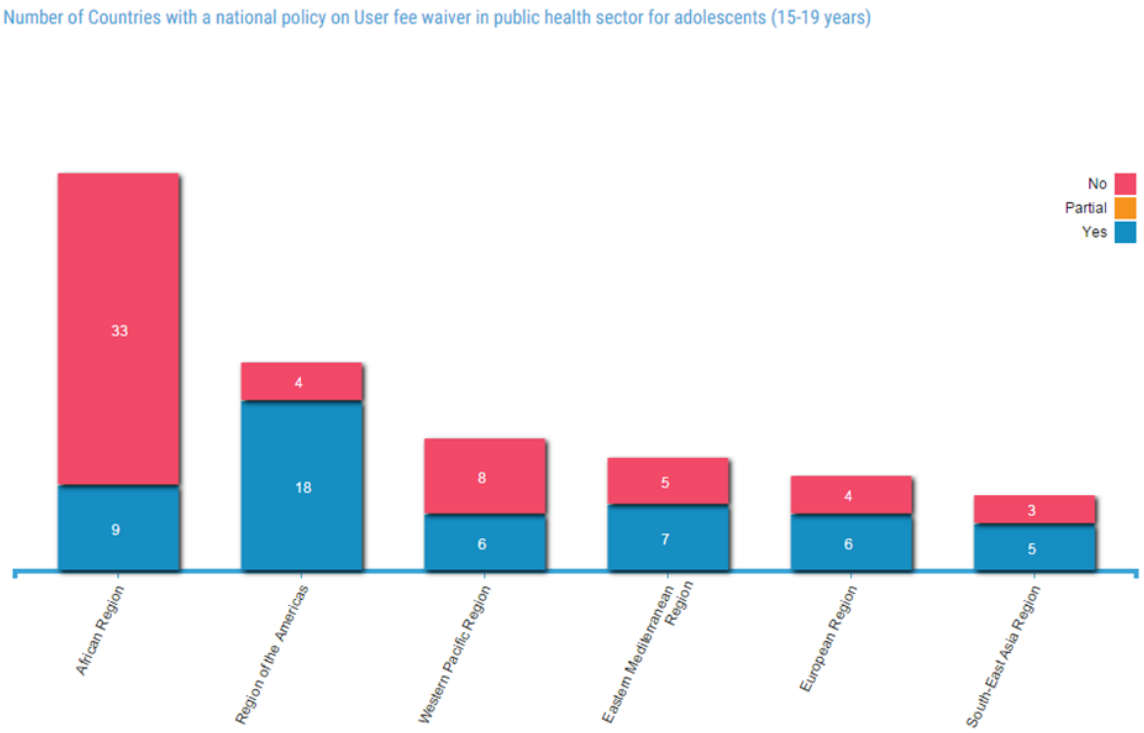

Figure A5.2. Number of countries with a national policy for a user fee waiver for adolescents in public health facilities.

Source: Information from countries that responded to the Global Maternal, Newborn, Child and Adolescent Health Policy Indicator Surveys (2009-10, 2011-12, 2013-14, 2016) undertaken by Department of Maternal, Newborn, Child and Adolescent Health; World Health Organization.

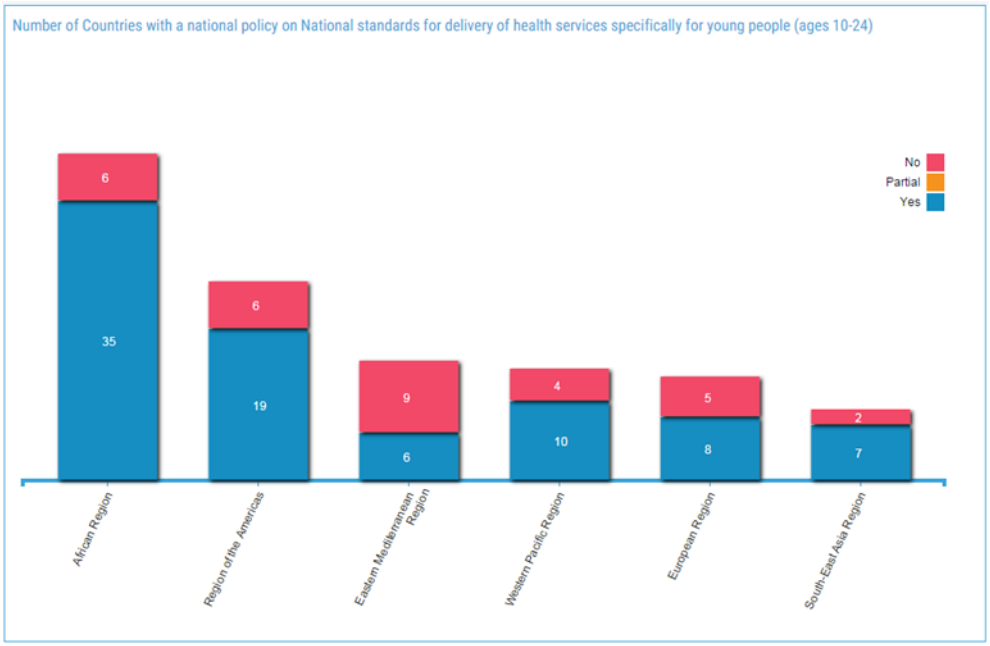

Figure A5.3. Number of countries reporting having national standards for delivery of health services specifically for young people (ages 10-24).

Source: Information from countries that responded to the Global Maternal, Newborn, Child and Adolescent Health Policy Indicator Surveys (2009-10, 2011-12, 2013-14, 2016) undertaken by Department of Maternal, Newborn, Child and Adolescent Health; World Health Organization.

A5.2. ADDITIONAL CASE STUDIES OF NATIONAL PROGRAMMING

CASE STUDY A5.1. Turkey's multi-sectoral action on drug dependence.

In Turkey, children in educational institutions and out-of-school children are among key target groups of the national Anti-Drug Emergency Action Plan that promotes strategies to address supply, demand, and communication policies in relation to substance use. Under the leadership of the Deputy Prime Minister and under the coordination of the Ministry of Health, a Higher Anti-Drug Board has been established to administer and implement anti-drug efforts within the scope of the Anti-Drug Emergency Action Plan. The Higher Anti-Drug Board coordinator is the Minister of Health, and the board is composed of the ministers of: justice, family and social policies; labour and social security; youth and sports; customs and trade; the interior; and national education; as well as the head of the Commission on Health, Family, Labour and Social Affairs of the national assembly.

The Higher Anti-Drug Board determines the basic anti-drug policies, monitors activities at a high level, and gives instructions for these activities. An Anti-Drug Technical Board composed of experts from relevant ministries works on the technical implementation of anti-drug activities. Anti-Drug Provincial Coordination Boards follow antidrug efforts to ensure that activities specified in the action plan are carried out in cooperation and coordination with the relevant institutions and organizations, and to monitor the whole process at provincial level.

Source: WHO EURO. 2016. Multisectoral action on drug dependence in Turkey: Applying a whole-of-government approach.

CASE STUDY A5.2. Argentina's municipal budgeting for youth participation.

The Municipality of Rosario in Argentina undertakes an annual participatory process to decide on the allocation of the youth budget, engaging youth from across its six districts in democratic processes to select representatives and decide upon budget allocations for youth services. An initial pilot in 2004 was funded by the German Technical Cooperation agency, but the necessary funds are now drawn from the municipal budget. Young people are able to have a say in the design of city youth services, and in the allocation of resources to support them. A representative of the municipal government said, "Where local young people are involved in budgetary decisions there is the potential to develop creative solutions to issues that can result in cost savings and better value for money. Local young people are often very conscious of spending and allocating public money and can therefore be very careful about how they spend it."

Source: UN, DFID/CSO Youth Working Group, and Restless Development. 2010. Youth participation in development: Summary guidelines for development partners.

CASE STUDY A5.3. Sierra Leone's involvement of children in the Truth and Reconciliation Commission.

During ten years of civil war, the children of Sierra Leone were deliberately and routinely targeted, and witnessed widespread and systematic acts of violence and abuse. They were abducted and forcibly recruited as child soldiers and were the victims of rape, mutilation, forced prostitution and sexual exploitation. Child combatants, themselves victims, took part in atrocities. Many were threatened with death if they did not do this, or were desensitized with drugs and alcohol.

The Truth and Reconciliation Commission (TRC) for Sierra Leone originated from the peace agreement and was established by an Act of the Sierra Leonean Parliament in February 2000. The main objective of the Sierra Leonean TRC was to create an impartial record of human rights violations. It was charged with recording those violations that occurred between 1991 and 1999 and making recommendations to the government to prevent future conflicts. What was unique about the mandate of the TRC in Sierra Leone was the attention it gave to the experiences of children affected by the armed conflict. It aimed to involve children throughout the process and adopted child-friendly procedures for children's participation. The TRC sought to build children's confidence and restore their sense of justice in the social and political order while, at the same time, establishing a mechanism of accountability for crimes committed against them.

Source: UNICEF 2004

CASE STUDY A5.4. The USA's expansion of minors' access to STI services.

Over the past 30 years, states within the United States of America have expanded minors' authority to consent to health care, including care related to sexual activity. All 50 states and the District of Columbia allow most minors to consent to testing and treatment for sexually transmitted infections (STIs), and many explicitly include testing and treatment of HIV. Many states, however, allow physicians to inform parents that the minor is seeking or receiving STI services when they deem it in the best interests of the minor. As of November 1, 2016:

1. All 50 states and the District of Columbia explicitly allow minors to consent to STI services, although 11 states require that a minor be of a certain age (generally 12 or 14) before being allowed to consent.
2. 32 states explicitly include HIV testing and treatment in the package of STI services to which minors may consent; many of these laws only apply to HIV testing.
3. 18 states allow physicians to inform a minor's parents that he or she is seeking or receiving STI services; however, with the exception of 1 state that requires parental notification in the case of a positive HIV test, no state requires that physicians notify parents about such services.

Source: Guttmacher Institute 2016 https://www.guttmacher.org/state-policy/explore/minors-access-sti-services,

CASE STUDY A5.5. South Africa's national policy on informed consent for testing children for HIV.

A child may give independent informed consent to an HIV test if he or she is:

1. Twelve years or older; or
2. Under 12 years of age but with sufficient maturity to understand the benefits, risks and social implications of a test.

If the child cannot give informed consent, it may be provided by:

3. The parent or caregiver of the child;
4. The provincial head of Social Development; or
5. A designated child protection organisation arranging placement for the child.

Where there is no parent, caregiver or designated child protection organization, informed consent may be provided by:

6. A superintendent or person in charge of a hospital.

Finally, where those listed above are unwilling or unable to consent, the Children's Court may consent to an HIV test where testing is in the best interests of the child.

Source: HSRC 2012

CASE STUDY A5.6. Malawi's cash transfer schemes as a vehicle to achieve public health objectives.

Cash transfers are direct transfers of money given to eligible households or individuals; most often the poorest households. They may be unconditional or conditional. They can improve health outcomes through enabling recipients to better manage risk, by contributing to economic growth, building social cohesion and supporting human capital development through greater use of health and education services, for example.

Cash transfers have shown promising results across many outcomes such as HIV, dietary quality, education, health care utilization, and parenting skills, among others. Cash transfer programmes can increase the use of health services and improve nutritional outcomes and preventive behaviours in situations where there is adequate health service provision. For example in Zomba, Malawi, cash transfers to adolescent girls and their households were associated with a 60% reduction in recipients' risk of HIV infection, against a background HIV prevalence of 22%. A variety of mechanisms might have contributed, including a reduction in early marriage and transactional sex, improved nutrition and healthcare use and, notably, the increase in school attendance enabled by the cash transfers.

The effectiveness of cash transfer schemes is affected by factors such as conditionality, targeting and the relationship to other social protection policies. It is important therefore to closely monitor the effect of these design features on the outcomes.

Source: WHO 2011f, Baird et al. 2010

CASE STUDY A5.7. Australia's HPV vaccination programme.

The free National HPV Vaccination Programme was introduced in Australia in 2007 because large trials had found that vaccinating young women was likely to significantly reduce Pap test abnormalities, cervical cancer diagnoses, and deaths from the disease. The vaccine also protects girls from some cancers of the vagina, vulva, and anus. The decision to introduce the programme in Australia was made by the Australian government after in-depth consultations with epidemiologists and public health experts. Since 2013, boys have also been included in the school-based programme.

The HPV vaccine is provided free in schools for girls and boys aged 12–13 years, and those who are not in school can obtain the vaccine for free from their local immunization provider or doctor. Almost all Australian schools have chosen to participate in the programme, and 77.4% of girls turning 15 years of age in 2015 had received all three doses of the vaccine. Research has shown early signs of the vaccine's success, including:

- A 77% reduction in the prevalence of the HPV types that are in the vaccine, which are responsible for about 75% of cervical cancers;
- Almost a 50% reduction in the incidence of high-grade cervical abnormalities in girls in Victoria under 18 years of age; and
- A 90% reduction in genital warts in heterosexual men and women under 21 years of age.

Sources: Cancer Council Australia. 2016. Has the program been successful? http://www.hpvvaccine.org.au/the-hpv-vaccine/has-the-program-been-successful.aspx.(accessed

26th Nov 2016); National HPV Vaccination Program Register. http://www.hpvregister.org.au/research/coverage-data/HPV-Vaccination-Coverage-2015 .(accessed 26th Nov 2016)

CASE STUDY A5.8. Nepal's transitions from projects to a national adolescent sexual and reproductive health programme.

The Nepal Health Sector Programme (NHSP) II (2010–2015), aimed to introduce 1,000 adolescent-friendly services (AFSs) in Nepal by 2015. Towards this, the Government of Nepal is implementing the National Adolescent Sexual and Reproductive Health (ASRH) Programme.

In 2008, the Family Health Division and Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH (GIZ, previously GTZ) started to discuss possible government interventions to improve the ability of adolescents to protect their sexual and reproductive health (SRH). Up until then, adolescent-specific health services and information had mainly been provided by nongovernmental and private health care providers. The Family Health Division conducted a pilot study for the introduction of AFSs into the existing network of public health facilities, in line with a rights-based approach to health. The National Adolescent Sexual and Reproductive Health (ASRH) Programme was subsequently designed based on the findings of the pilot study. The Programme was conceptualized in line with the objectives of the National Adolescent Health and Development Strategy 2000, which are to:

- Increase the availability of, and access to, information about adolescent health and development and provide opportunities to build the skills of adolescents, service providers and educators;
- Increase the accessibility and utilization of adolescent health and counselling services; and
- Create safe and supportive environments for adolescents in order to improve their legal, social and economic status.

Cooperating with other actors in the field of SRH (including schools) is one of the components of the programme, although the mid-term evaluation showed that this coordination needs to be strengthened in order to effectively impart information about ASRH issues and sensitize adolescents about the availability of adolescent-friendly services at health facilities.

The scaling-up process was funded directly by the Government of Nepal and different partner organizations working in the ASRH sector, such as GIZ, the United Nations Population Fund (UNFPA), Save the Children, the World Health Organization (WHO), and UNICEF. By November 2012, the National ASRH Programme had been scaled up to 516 health facilities in 36 districts. If the target of introducing 1,000 AFSs in the public health system by 2015 was to be achieved, coverage would reach about 25% of all government health facilities.

Source: Ministry of Health of Nepal (2013)

CASE STUDY A5.9. Chile's national programme for integrated adolescent and youth health.

The Programa Nacional de Salud Integral de Adolescentes y Jóvenes seeks to improve health systems and the quality of comprehensive health services to meet the needs of adolescents, with an emphasis on the primary care level. The minister of health is the main person responsible for the implementation and development of the programme. The responsibilities are shared between national, regional, and local levels. Even though the programme is focused on the health sector, nine strategic directions have been identified for the period 2012-2020 that emphasize the need for better advocacy and strengthening of inter-sectoral work; family, community, and school-based interventions; adolescent participation; and the use of social media and networks.

Source: Government of Chile. 2013. Programa Nacional de Salud Integral de Adolescentes y Jóvenes: Plan de Acción 2012-2020.

CASE STUDY A5.10. Mozambique's multisectoral adolescent sexual and reproductive health programme.

The Programa Geracao Biz in Mozambique is a national multisectoral adolescent sexual and reproductive health programme, which started in 199 aiming to improve sexual and reproductive health (SRH) and rights through the creation of enabling environments for improved knowledge, attitude and abilities of young people for adopting positive SRH behavior and accessing services from youth.friendly clinics.

Geracao Biz involved three sectors – health, education, and youth and sports. Government staff from each of these sectors worked with community-based organizations, including youth organizations, and young people to deliver three complementary but linked interventions - youth friendly clinical services, school-based education and community-based outreach. To facilitate collaboration, a strong coordination mechanism was put in place – at the national, provincial and district levels. Young people were active members of coordination committees at all three levels.

Between 1999 and 2009 the programme was funded by UNFPA and the Danish International Development Agency, with additional support from NORAD and SIDA. Pathfinder International provided ongoing on-the-ground technical support.

The results:
The initiative was launched in 1999 in two pilot sites. Over the next ten years, it was scaled up to cover all the provinces of the country. According to an independent external evaluation of the initiative, since 2010 the programme has been implemented in 119 of the 128 districts of the country, and reaches 56% (over 4 million) of the youth, and 220 (54%) of the 408 administrative posts in the country."(3)

Between 2005 and 2010 there was a decline in the number of reported pregnancies among students, while during the same period, the number of participating schools increased from 283 to 710.
Lessons learned:
Government leadership and support:
- There was support for the initiative from the highest level of the government. The availability of an enabling policy and a dedicated unit in the Ministry of Health meant that the initiative had the legitimacy to move ahead and had the leadership it needed.

Design:
- The initiative started with a good understanding of the epidemiologic situation and was well informed by a situation assessment which demonstrated the need for multisectoral action.
- The objectives of the initiative were carefully thought through and set out clearly.
- The responsibilities of each sector were laid out clearly and clear coordinating mechanisms were set up at the national, provincial and district levels.
- The brand was developed with through consultation with communities.

Pilot tests:
- Pilot projects were designed and implemented. There was substantial mentoring and coaching in the pilot phase. The pilot phase was externally evaluated, and the findings and lessons learned informed the planning of the subsequent phases.

Scale up and Continuity:

- The initiative was designed from the outset for scaling up. New partners were brought in to support expanded coverage of the program.
- The initiative was designed for sustainability by being grounded within existing government structures (e.g. clinics and schools) and by institutionalizing activities such as training (e.g. by adding adolescent sexual and reproductive health content into existing training programmes), and including adolescent-specific indicators into the national Health Management Information System).

Implementation:

- Serious attention was paid to implementation. Ongoing technical support was provided both on managerial and on technical issues. Capacity building was a major area of focus.
- There was considerable flexibility. The objectives of the initiative evolved with time as lessons were learned. The scope of the initiative was broadened in response to the needs and opportunities, and in response to evaluation findings. The key players involved in the initiative from the different sectors and the coordination mechanism also evolved over time.
- Adequate funds were generated to translate words into actions. Concerted efforts were made to bring new donors on board.

Challenges:
The external evaluation of Geracao Biz recommended that, while building on its good work of providing adolescents with information, education and health services, the programme should also address the powerful social, economic and cultural factors that drive the decisions adolescents make, and which of their decisions they act upon.

Sources: G Hainsworth, I Zilhao, R Badiani, D Gregorio, L Jamisse, A Modan, J Pacca. From inception to large scale: the Geracao Biz programme in Mozambique. WHO and Pathfinder International. Geneva. 2009; J Matsinhe. Programa Geracao Biz. Investing in youth: The story of a national sexual and reproductive health programme for adolescents and youth in Mozambique. UNFPA, Maputo. 2011; M Sanchez, K Taela, P Pateguana, C Singano, E Whist. In-depth review of the Geracao Biz Programme in Mozambique. Scanteam (www.scanteam.no). 2012. Oslo.

CASE STUDY A5.11. The USA's school health services program.

CDC's Healthy Schools program supports all 50 states and the District of Columbia (DC) in USA to reduce the risk factors associated with childhood obesity, manage chronic conditions in schools, and promote the well-being and healthy development of all children and youth. The Healthy Schools program supports the implementation of evidence-based school health strategies by funding state health departments, providing technical assistance, and developing specialized tools and resources to facilitate collaboration between state health and education agencies. This funding facilitates collaboration across sectors through memoranda of agreements between state public health and education agencies.

The programme funds two components: the basic component, which provides base-level funding to all 50 states and DC; and the enhanced component, which provides additional resources to 32 states for more intensive school-based interventions and greater health outcomes. For example, the school health services programme in the state of Colorado is run by the Department of Education and the Department of Health Care Policy and Financing. The programme contains many components, including the provision of psychology, counselling, audiology, nursing and physician services, as well as social support and targeted case management. Any educational institution with students in kindergarten through twelfth grade (up to the age of 20 years) may participate. Institutional participation in the program is conditional on fulfilment of enrolment criteria, including:

- An assessment of the health needs of students in the district;

- Community input into the health services to be delivered to students;
- An approved local services plan completed by the district; and
- A contract for reimbursement of health services by Medicaid, a program that was created by the federal government but is administered by the state to provide payment for medical services for low-income citizens.

Sources: https://www.colorado.gov/pacific/hcpf/school-health-services-program
http://www.cdc.gov/healthyschools/stateprograms.htm

CASE STUDY A5.12. Portugal's healthy schools programme.

The Healthy Schools Programme in Portugal aims to facilitate the implementation of structural and integral health promoting activities in schools. The work started in 1994 with ten schools and four health centres in the national health service. By the end of 2000, the network had extended to 1,957 health promoting schools and 255 health centres. By 2002, the number had grown to 3,407 schools.

Each year, the programme supports and finances school projects. To date, the vast majority of participating schools have developed projects in healthy eating and physical activity (99%), drug prevention (98%), sexual education (98%), and mental health and violence prevention (94%).

It has been reported that part of the success of this programme is due to the partnership between the Ministry of Health and the Ministry of Education and Science, which is well established nationally, regionally, and locally. The partnership between schools and health centres is particularly key. Both Ministries also developed, in partnership, two manuals with health promoting school guidelines for teachers and for health professionals.

Source: Schools for Health in Europe. 2016. Portugal. Accessed at www.schools-for-health.eu/she-network/member-countries/36/portugal.html.

CASE STUDY A5.13. South Africa's participatory, same-sex health education programme.

Stepping Stones aims to reduce HIV transmission, improve sexual health and build gender-equitable relationships. It involves a series of training sessions in which facilitators work with same-sex peer groups to question and explore issues of love, contraception, STI, sexual health, gender-based violence and communication between partners. The programme has been adapted to many contexts worldwide, including in Africa, Asia, Europe, Latin America and North America. This case study discusses its application in South Africa, where Stepping Stones was implemented in the Eastern Cape Province between March 2003 and March 2004.

The main objectives of Stepping Stones include:
• To reduce the incidence of HIV transmission;
• To encourage men and women to explore gender issues, their emotional needs and their communication and behaviour towards each other;
• To address the vulnerability of women and young people in decision-making about sexual behaviour;
• To address and explore a range of behaviours that affect sexual health; and
• To improve sexual health by forming intimate partner relationships that involve gender equity and good communication.

The programme was conducted with young men and women 16–23 years old. Thirteen sessions lasting three hours each were held with participants over several weeks. Participants were separated

into all-male and all-female peer groups, creating a safe space for exploring and discussing sensitive issues. The issues discussed included sexual behaviour, unintended pregnancy and gender-based violence. Participatory methods such as drawing activities and role-play were used. Skills promoting assertiveness were taught. Participants also discussed the motivations behind sexual behaviour and the prospect of changing behaviour.

A cluster randomized controlled trial was conducted. Villages were randomized to receive the Stepping Stones intervention or an alternative intervention. The alternative intervention involved a single three-hour session promoting safer sex. The main outcome measured was the incidence of HIV infection. The incidence of herpes simplex virus infection, reported sexual behaviour, substance abuse, depression and undesired pregnancies were also measured one and two years after the programme was implemented.

Two years after the programme was implemented, men reported less violent behaviour towards their intimate partners. Men also reported less transactional sex and less excessive drinking. The incidence of herpes simplex virus 2 infection was lower in the intervention arm during the two-year period, although the incidence of HIV infection was nor significantly different in the intervention and control arms. Thus, while the programme did not reduce HIV incidence it did reduce self-reported risky behaviours that contribute to HIV transmission: reported domestic violence, forced intercourse and transactional sex all declined one to two years after Stepping Stones was implemented.

Sources: 112-115 from : http://www.who.int/gender-equity-rights/knowledge/health_managers_guide/en/

CASE STUDY A5.14. El Salvador's intersectoral experience in the empowerment of adolescent girls.

The "Interagency Program for the Empowerment of Adolescent Girls (IPEAG)" was established through a group of United Nations agencies (UNDP, UNFPA, FAO, UNICEF and PAHO) to promote intersectoral work in addressing the needs of adolescent girls. The Ministry of Public Health and Social Assistance of El Salvador had a history of support for social participation and intersectoral action and supported the initiative through the Integrated Care Unit for Adolescent Health. In a patriarchal society like El Salvador, young women are often marginalized and victims of systemic discrimination. Support for adolescent girls was therefore identified as an important health equity issue. Health promotion strategies were supported through innovative activities such as a mural contest on the topic of birth control. Adolescents were also responsible for the production of a variety of educational and audio-visual materials on sexual and reproductive health. Specialized Integrated Care Units for Adolescent Health were established in 13 targeted communities that were staffed by multidisciplinary personnel who were trained in adolescent care. Eleven revenue-generating enterprises, managed by adolescent girls, were also created.

A lack of baseline data unfortunately limited the systematic evaluation of the programme, although there is widespread acceptance that it has succeeded in empowering adolescent girls and young women in the affected communities. Although the programme was national in scope, a report on the programme emphasized the need for more intensive and sustained participation by local government.

Source: Avalos, M. E. (August 2007). Intersectoral Experience in the Empowerment of Adolescent Girls.

CASE STUDY A5.15. Australia's government funding of positive development approaches in programming.

The Victorian Health Promotion Foundation (VicHealth) is pioneering health promotion in Australia on behalf of the government. The organization aims to design evidence-based interventions, fund health promotion programmes, conduct research, and produce and support public campaigns to promote a healthier Victoria. VicHealth receives core funding from the Australian Department of Health, and most of the members of the VicHealth board are appointed by the Minister for Health. Funds are provided to deliver on five strategic objectives: promoting healthy eating, encouraging regular physical activity, preventing tobacco use, preventing harm from alcohol, and improving mental wellbeing.

Positive development approaches are central to VicHealth's work. As the Foundation states, "pinpointing and preventing the negative influences of ill health, and championing the positive influences on good health, is central to our work". For example, through its Bright Futures Challenge projects, VicHealth is providing substantial grants to projects that aim to support the resilience, social connection and mental wellbeing of young Victorians.

Source: VicHealth 2016

A5.3. CHARACTERISTICS OF SUCCESSFUL PROGRAMMES

The ultimate characteristic of a successful programme is evidence of positive impact. Unfortunately, the majority of adolescent health programmes have very weak monitoring and evaluation systems, and they are often not able to show results beyond inputs and process evaluations. Notable exceptions are projects and programmes that are implemented as research projects, or as part of donor-driven projects that require rigorous logical frameworks to justify programme assumptions and activities, solid evidence-base for the interventions selected, quality control during implementation, and robust evaluations as a prerequisite to accessing funds. National and subnational adolescent health programmes should share the same concern for rigour and accountability for the investments made as programmes that are implemented as research projects, or as donor-driven projects.

Successful programmes share some common characteristics. Programmes should be designed and implemented taking the following ten key characteristics into consideration:

1. ***Political leadership:*** support for the programme from the highest level of the government, with the availability of an enabling policy environment and a dedicated Adolescent Heath Unit in the Ministry of Health (See also Key Area for Programming nos. 1.2).
2. ***Shared vision among key stakeholders***: This relates to all aspects of the programme, including a shared vision of the problems to be addressed, potential solutions and consensus about how to define success. Engaging key partners at the very beginning is important, including civil society organizations, academia, the business community, media, and funders. Organizations and individuals involved in partnerships need to have both the authority and the flexibility to engage in mutual decision-making. Clarity about partners and stakeholders is key: who, how many, their roles and responsibilities, and the need for consistency of participation and commitment.
3. ***Adequate financing:*** Discretionary funding for national, sub-national, and local activities should be available and maintained throughout the programme. Funding should be allocated to local areas through programme implementation grants and contracts that are subject to conditions, such as appointing local coordinators and developing local plans (Case Studies 41 and 42).

4. ***Adolescent and community participation:*** This includes all aspects of programming, including design, implementation, monitoring and evaluation (See Key Areas for Programming nos. 8-16).
5. ***Contextually-appropriate implementation and an effective local strategy:*** Implementation of planned activities should consider local contexts and an effective local implementation strategy should mirror national plans. Critical components of such local strategies are: strong local coordinators, active use of data for fund disbursement/commissioning and monitoring of progress; service provision strategies in different settings; linkages between health services and schools; support for parents; targeted prevention for at-risk populations; and consistent communication for and between key community stakeholders.
6. ***Documentary support for local implementation:*** Guidance materials and manuals facilitate dissemination of programmes and fidelity in their implementation. Key areas where such resources are valuable include: community and youth engagement; district planning; working across disciplines and government sectors; public/research/practice partnerships; core indicators and measures; and specific health issues.
7. ***Evidence-based multi-component programmes and interventions:*** The most effective programmes are usually multi-component with interventions acting at more than one level of the ecological framework (i.e. structural, organizational, community, interpersonal and individual levels), and targeting more than one setting (e.g. health facilities and schools). As much as possible, programme components should be based on scientific evidence from high-quality evaluations that indicate that significant positive change in the intended outcomes can be attributed to the selected interventions. Summaries of programmes that have shown positive outcomes exist, such as the registry of effective programmes for the prevention and treatment of mental health and substance use disorders (Box A5.1).
8. ***Intervention specificity:*** The programme description should clearly identify the outcome that the programme is designed to change, the specific risk and/or protective factors targeted to produce this change in outcome, the population for which it is intended, and how the components of the intervention will work to produce this change.
9. ***Organizational capability:*** A successful programme: (a) reaches and builds the capacity of a wide variety of health professionals, programme administrators, and policy makers to assist them in the development of local plans, service delivery, and research; (b) collaborates with key national research centres and institutions, and leverages their resources for intervention development and implementation research; and (c) develops the core capacity of other ongoing adolescent health and development programmes (e.g. national mental health programmes; HIV programmes).
10. ***A clear assessment, monitoring, evaluation, and reporting framework:*** See Section 6.

(EWEC 2016; Hadley et al. 2016; Dick 2013; Lancet 2016.)

Box A5.1. Registries of evidence-based mental health and substance use disorder programmes.

a. Blueprints for Healthy Youth Development is a registry that identifies evidence-based programmes to help young people reach their full potential in areas such as through interventions to reduce bullying in schools, youth violence, teen substance abuse, antisocial, aggressive behaviour, childhood obesity, school failure, delinquency, and youth depression/anxiety. http://www.blueprintsprograms.com/
b. The Substance Abuse and Mental Health Administration in the US maintains the “National Registry of Evidence-Based Programs and Practices”. Its purpose is to help the public and professionals find methods and programmes that have been proven to be useful in the prevention and treatment of mental health and substance use disorders. http://www.samhsa.gov/nrepp

c. The Suicide Prevention Resource Center and the American Foundation for Suicide Prevention jointly created the Best Practice Registry. This registry provides information about suicide prevention and intervention programmes that have shown positive outcomes. It also provides summaries of current suicide prevention knowledge and provides a listing of strategies that follow standards. http://www.sprc.org/resources-programs
d. The European Monitoring Centre for Drugs and Drug Addiction provides details on a wide range of evaluated prevention, treatment, and harm reduction interventions, as well as interventions within the criminal justice system. http://www.emcdda.europa.eu/themes/best-practice/examples/resources

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A5.4. REFERENCES [Section 5 and Annex 5 combined]

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