

# ACT NOW FOR ADOLESCENTS

Adolescence is a critical phase for achieving physical, cognitive, emotional, social and economic capacities that are the foundation of future adult and societal health and well-being.<sup>1</sup> Compared with the progress in infant and child health from 2000 to 2012, wherein all causes of childhood mortality declined,<sup>2</sup> adolescents (persons 10-19 years are the focus here, but many considerations apply also to young adults 20-24) have benefitted less from the 'epidemiological transition'. Adolescent mortality declined by only 12% compared with an under-five mortality decline of 52%, partly because of the increase in AIDS-related adolescent deaths.<sup>2</sup> Adolescents are often seen as the healthiest cohort and yet, WHO estimates suggest that each year, nearly one million adolescents die from preventable causes, tens of millions suffer injuries, and hundreds of millions develop harmful behaviours with short- and long-term health and non-health impacts.<sup>2</sup> Despite these challenges, a recent stronger global response to adolescent health is helping to reverse these trends. This Knowledge Summary briefly highlights achievements and gaps, and future priority actions.



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# The Opportunity

## Why We Must Act Now

The Sustainable Development Goals (SDGs) 2016-2030<sup>3</sup> give more prominence to adolescent health. A clearer understanding of environmental and individual determinants of health in adolescence<sup>4</sup> is further advanced by the publication of the Lancet Commission on Adolescent Health and Wellbeing,<sup>5</sup> and the updated Global Strategy for Women's, Children's and Adolescents' Health and the Every Woman Every Child (EWEC) movement.<sup>1</sup>

Adolescents are at a distinct, formative developmental stage, experiencing puberty and neurocognitive maturation and exploring their place in the world.<sup>6</sup> Healthy behaviours, self-esteem, skills and competencies established in adolescence benefit both adolescents and their societies.<sup>7,8</sup> The current cohort of adolescents is the largest in history because of demographic transition and recent gains in child health.<sup>9</sup> There is an ever-greater responsibility to support adolescents, as well as an unprecedented opportunity to benefit from this demographic dividend. The latter refers to the potential for socio-economic development presented by having large numbers of young people relative to the proportion of dependent children and the elderly in the population. The dividend is realised if young people are educated, healthy,

## Box 1

The three most common causes of preventable deaths in adolescents are road injuries (particularly in males), HIV and self-harm. For girls, complications of pregnancy and childbirth, including unsafe abortion, child marriage and female genital cutting are also major risk factors. Mental health problems, notably unipolar depression, often start in adolescence and can have life-long impacts. Many adolescents, particularly males, initiate harmful behaviours, such as the use of drugs, tobacco and alcohol. Both sexes may engage in sexual and other risk taking behaviour, have a poor diet, and low physical activity. Interpersonal male-on-male violence is a widespread concern, as well as the development of harmful gender biases and sexual and gender-based violence, where women are disproportionately affected.<sup>1,2</sup>

confident and safe, they can find employment, control their reproduction, and are therefore able to contribute effectively to their nation's development. Adolescents are essential human capital and drive current and future economic and social progress. Investments in adolescent health and well-being can thus be viewed as having a triple dividend with health benefits for adolescents today, for the adults they will become, as well as the next generation.<sup>5</sup>

# What We Know

## Achievements and Gaps

The 1994 International Conference on Population and Development (ICPD) Programme of Action<sup>10</sup> highlighted adolescent sexual and reproductive health, influencing the Millennium Development Goals (MDGs)<sup>11</sup> and, more recently, the SDGs.<sup>3</sup> The updated Global Strategy<sup>1</sup> explicitly includes adolescents and builds on lessons learnt.<sup>12</sup> An operational framework, the Global Framework for Accelerated Action for Adolescent Health, has been developed and increased financing pledged.<sup>13</sup> Although still insufficient, meaningful youth participation is growing: prominent examples include the Bali Youth Forum's Declaration<sup>14</sup> at the 2012 global ICPD review, African Youth and Adolescents Network (AfriYAN) in 20 African countries, the adolescents technical content work stream for EWEC, and formation of the youth constituency of the Partnership for Maternal, Newborn and Child Health (PMNCH). UNAIDS and the Africa Union emphasise empowering young women and adolescent girls to prevent HIV infection.<sup>15</sup>

From countries as diverse as Estonia,<sup>16,17</sup> Uganda,<sup>18,19</sup> and the United Kingdom,<sup>20</sup> evidence is mounting of effective programming for different aspects of adolescent sexual and reproductive health (ASRH), primarily for 15-19 year olds.

Two important approaches are the provision of comprehensive sexuality education (CSE) and youth-friendly sexual and reproductive health (SRH) services. These programmes adhere to specific criteria, including community embeddedness, and implementing a core package of inter-related actions in the context of a safe and supportive environment.<sup>1,2,21</sup>

Nonetheless, most countries lack comprehensive national policies for adolescents, and programmes are often patchy and based on insufficiently disaggregated data.<sup>1,2,20</sup> Primary reasons for weak policy frameworks and inadequate implementation include: competing priorities and limited commitment to adolescents as a special group; insufficient funds; discomfort regarding key adolescent health issues among policy makers, service providers and parents; lack of technical capacity in adolescent health programming; and poor accountability. There may be low awareness of environmental and individual determinants of adolescent health and the challenges they face. Lessons learnt are not shared widely, rigorously applied and/or brought to scale. Adolescents are usually subsumed in health systems within programmes for children or adults, without attention to specific age-related needs, marital status, or gender. Critical gaps remain in disaggregated demographic and

health data, as well as knowledge around scaling up and sustaining effective projects or programmes while retaining quality and intensity.<sup>1,2</sup> Detailed operations research in different contexts is also lacking.<sup>22</sup> Data are particularly poor for younger adolescents (10-14) and for adolescents in key populations affected by HIV, substance abuse, humanitarian settings and physical, mental or social abuse.

Furthermore, potential multi-sectoral partners may not always collaborate due to a lack of awareness of the benefits of interlinked approaches or different priorities and mandates that are not easily integrated. Finally, youth-led networks are insufficiently supported and empowered; strengthening them would help ensure that adolescents' voices are heard and valued.

## What Works

### Priority Future Actions

**Adolescents' basic needs and rights need to be met within enabling environments for them to survive, thrive and develop their full transformative potential.**

The definition of health and well-being needs to be universal and holistic, and the response should be multi-dimensional. Meeting the basic needs and rights of adolescents requires multiple constituencies to collaborate effectively through functional structures at all levels.

Policy and programming for adolescents should combine public health priorities with a strong human rights<sup>1,2,5,23</sup> and gender transformative approach, raising accountability and transforming a client-service frame into one of obligation between duty bearers and rights holders. Despite their commonalities, the needs of adolescents 10-19 vary widely, and responses must be tailored based on local circumstances, age, sex, gender, educational and marital status, and other factors.

Figure 1 provides a model of the interlinked determinants of adolescent health and well-being that underlie multiple risk behaviours, health literacy and the adoption of care-seeking behaviours. Long-term, structural factors, such as national wealth and income inequality, play a key role.<sup>4</sup> Using prevention science approaches to address simultaneously different levels of risk, and to promote protective factors, shows potential to contribute to better programming in countries.<sup>24</sup>

Different means are required to communicate programme and research results effectively to diverse audiences.<sup>21,22</sup> Appropriate messaging is thus key to translating both what worked and what did not, and to enable learning.

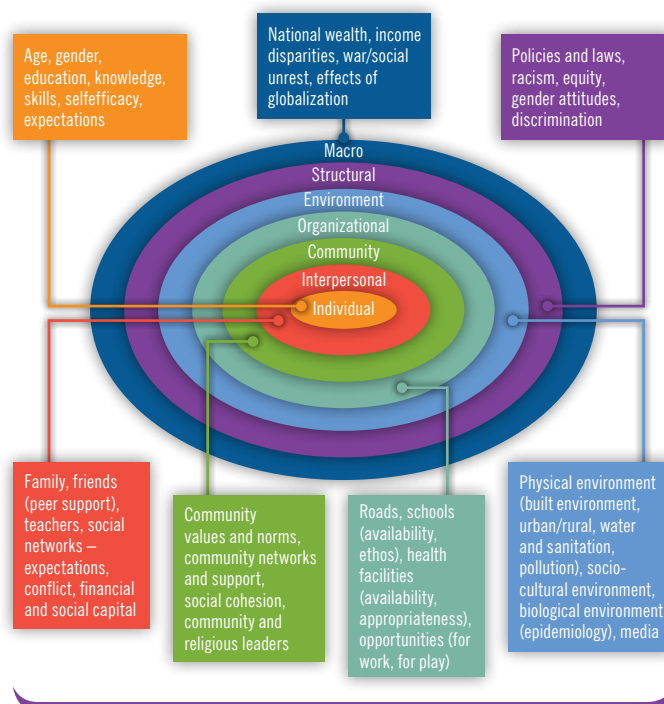
**It is important to identify, prioritise and implement to scale a small number of interlinked, evidence-based approaches specific to local contexts, needs and gaps.**

Ensuring robust assessment of feasibility and sustainability over time without losing sufficient intensity, quality or coverage can yield lasting results. Key measures include:

- Identifying critical unmet needs and strategic opportunities for bold, innovative actions;
- Undertaking simple actions at scale to address unmet needs (such as for iron-folate, deworming, Human Papillomavirus and other vaccines, and basic commodities including contraceptives, condoms and sanitary products), including of marginalised and vulnerable groups. Where feasible, use

**Figure 1**

**Determinants of adolescent health and development: an ecological model<sup>2</sup>**



these actions as entry points and incorporate strategies to achieve wider outcomes and reach meaningful targets;

- With rigorous process monitoring and evaluation of results,<sup>22</sup> developing a package of complementary interventions, each of which is delivered based on known criteria for success;
- Closely documenting new approaches relevant to adolescents in different contexts, and sharing lessons learnt.

**Governments, with multi-sectoral partners, need to set nationally realistic, yet sufficiently ambitious outcome and impact targets against known baselines in order to assess trends over time.**

Monitoring frameworks need to use SMART (specific, measurable, achievable, relevant, time-bound) and internationally agreed indicators,<sup>25</sup> and to reflect a gender-transformative approach. Key measures include:

- Collecting, analysing and disseminating trend data, disaggregated by sex and age (at a minimum, age groups

10-14, 15-19, 20-24) and by other demographic and criteria such as educational, socio-economic and marital status;<sup>26</sup>

- Undertaking gender audits of policies, strategies and programmes and ensuring that they espouse gender transformation to benefit both females and males;
- Developing capacity to utilise available trend data to inform adolescent health policies and programmes, and ensuring commensurate funding needed to deliver results.

### **To deliver key services, support and information that adolescents need, develop effective and sustainable partnerships and mechanisms.**

Strategic collaboration is required between diverse sectors including governments, civil society, international development agencies, communities, adolescents and other stakeholders. Other effective approaches could include the increased use of interactive media and affordable new technologies to promote linkages, particularly those favoured by young people. Increasingly, private-public partnerships provide considerable support but require strong accountability frameworks to safeguard against profit-making, without commensurate health and social gains. Additional actions include:

- Building the capacity of, and creating opportunities for, networks of adolescents and young adults to participate effectively in relevant policy-making, programme design and implementation and assessment, and documenting the outcomes of their active involvement;
- Ensuring that health, welfare, education, law enforcement, humanitarian responses and other systems integrate adolescents' needs in staff training, financing, monitoring, and in special service provisions (e.g. for adolescents with disabilities, gender and interpersonal violence, girls at risk of child marriage, and youth involved in gangs or substance abuse, and young people in humanitarian settings).

### **Advocate for countries to develop and enforce supportive legislation and policy frameworks.**

Supportive legislative, policy and regulatory frameworks,

## **Box 2**

Collaboration between, and actions by multiple sectors (for instance health, education, social protection, employment and justice), can contribute significantly to adolescent health and well-being. For instance, schools can provide a supportive environment for physical and mental health as well as health and sexuality education; adolescent safety can be enhanced by preventing violence and improving road safety; mass media can encourage healthier social norms; safe, non-exploitative work opportunities can assist adolescent development.<sup>2</sup>

while insufficient on their own,<sup>27,28</sup> create the enabling environment<sup>29,30</sup> needed to safeguard adolescents, particularly regarding sexual orientation, informed consent for HIV testing,<sup>31</sup> and accessing harm reduction measures.<sup>32</sup> Additional steps include:

- Promoting accountability through effective oversight to ensure that legislation and policies are consistently adhered to, duty bearers are adequately trained, and individuals know their rights;
- Utilising proven community development strategies and ensuring that positive legislation is backed by strong community programmes to change harmful traditions and practices (e.g. child marriage);
- Actively involving gatekeepers, service providers and opinion-leaders, as well as adolescents themselves.

**Strengthen implementation research to understand why different approaches do or do not work in different settings and for different adolescents.** Efforts may be short-term with insufficient intensity, or applied piecemeal without the complementary elements that build success;<sup>21</sup> they may miss the most marginalised or vulnerable, or only measure short term results. Likewise, some programmes fail to engage the community and address structural impediments to adolescent health, or to provide interlinked services.

## **Box 3**

In a regional report on school-based CSE commissioned jointly by UNESCO, UNFPA and UNICEF, only a few out of the 10 countries assessed in East and Southern Africa<sup>33</sup> met international standards. Furthermore, little attention was paid to empowering adolescents with agency and advocacy skills, despite evidence that these are essential for success,<sup>34</sup> as are factors such as community engagement and complementary actions.

## **Conclusion**

**W**ith global and national commitment, we must ensure that adolescents survive, thrive and contribute to transforming their future. The timing is strategic to build on the health gains in the first decade, and to utilise evidence-informed frameworks and guidelines. We can and must all rise to the challenge to address the most pressing needs and rights of all adolescents, everywhere.

Available on-line at <http://www.who.int/pmnch/knowledge/publications/summaries/en/>

A list of useful resources and references numbered in this text is available online at: <http://www.who.int/pmnch/knowledge/publications/summaries/ks35/en/>